DOCUMENT RESUME

ED 088 303 HE 005 092

TITLE Philadelphia Student Health Project Summer 1968.
INSTITUTION Health Services and Mental Health Administration (DHEW), Bethesda, Md.
PUB DATE 69
NOTE 140p.

EDRS PRICE MF-$0.75 HC-$6.60
DESCRIPTORS *Health Occupations Education; *Health Services; *Higher Education; Poverty Programs; School Community Relationship; *Student Experience; *Student Projects
IDENTIFIERS *Philadelphia; Student Health Organization

ABSTRACT

The Philadelphia Student Health Organization Summer Health Project had as a purpose to collect information relevant to the following categories: (1) descriptions of new kinds of cooperative arrangements; (2) descriptions of features of community organizations; (3) description of the health status of poor populations; (4) evaluation of the present adequacy of health care programs; (5) estimation of health attitudes of poor populations; and (6) descriptions of new methods for obtaining information relevant to the above questions. Section I of the report provides some background information to help orient the reader to the project. Section II presents papers concerning the problems assessed by the Student Health Organization. Section III contains project worker personal contact reports. Section IV presents an evaluation of the educational and attitudinal impact of the project on student participants as well as some general comments on the significance of the project as a whole. The various research instruments designed and used by the researchers in obtaining their information are contained in the Appendices of Section V. A list of the projects and the project participants appears in Section V also. (Author/PG)

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PHILADELPHIA STUDENT HEALTH PROJECT summer 1968

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U.S. Department of Health, Education, and Welfare
Public Health Service
Health Services and Mental Health Administration
Division of Regional Medical Programs
This project was supported in full by
(Contract No. 43-68-1533)

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PHILADELPHIA
STUDENT HEALTH PROJECT
1968

FOREWORD

The reports included in this volume describe the variety of experiences available to health professional students during the summer of 1968. Although some accounts of activities are more complete than others, some far more sophisticated than others, and many are naive, the impact of all these experiences on the reader is profound.

Young professionals, at the threshold of their careers, have had a real opportunity to observe the complexities and inequities of our health and welfare delivery systems, and to record their impressions of these experiences.

The interest expressed by Regional Medical Programs in service delivery systems has been served well in that the participants were enabled to observe at first hand the current problems in the delivery of services. It can be predicted that none of these students will be content, in the future, blindly to accept the status quo.

These students have worked conscientiously and maturely in accomplishing their goals. I consider it a privilege to have been associated with them and with the Student Health Project, Philadelphia, 1968.

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Associate Professor of Clinical Psychiatry
and Director of Division of Community
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Director, West Philadelphia Community
Mental Health Consortium

Director, Student Health Organization

Preface and Acknowledgments

The Philadelphia Student Health Organization Summer Health Project was funded by the Division of Regional Medical Programs (Contract #PH-43-68-1533), and the work-scope of the contract indicated that the purpose of the project was to collect information relevant to the following categories:

1. Descriptions of new kinds of cooperative arrangements.
2. Descriptions of features of community organizations; how they facilitate and/or block attainment of RMP objectives.
3. Description of the health status of poor populations.
4. Evaluation of the present adequacy of health care programs.
5. Estimation of health attitudes of poor populations.
6. Descriptions of new and creative methods for obtaining information relevant to the above questions.

This report is, therefore, primarily a response to the contractual agreement with the Regional Medical Programs. The papers of the project workers are collected in sections II and III together with comments by the research directors, Miss Karen Lynch and Mr. Jon Snodgrass. These sections are the core of the report and contain the material relevant to the stated purpose of the project.

Section I provides some background information to help orient the reader to the papers that follow. Section IV presents an evaluation of the educational and attitudinal impact of the project on student participants as well as some general comments on the significance of the project as a whole. The various research instruments designed and used by the researchers in obtaining their information are contained in the appendixes of Section V. A list of the projects and project participants appears in Section V also.

In addition to Drs. Richard F. Manegold and Herbert O. Mathewson of the Division of Regional Medical Programs, other individuals and groups who were instrumental in making the project possible are the following: George Silver, M.D., Joseph English, M.D., Mrs. Edna Rostow and Mrs. Carol Simons, who helped with negotiations in Washington during the winter and spring of 1968; Leo Molinaro, I. Milton Karabell, and members of the Board of Directors of the West Philadelphia Corporation, who approved the arrangement whereby the corporation acted as the grantee and official administrator of the funds of the project; Gaylord P. Harnwell, who was instrumental in providing for use of University of Pennsylvania funds by the project, later to be reimbursed by the government on presentation of vouchers; and, finally, Robert L. Leopold, M.D., and almost the entire staff of the West Philadelphia Community Mental Health Consortium, on whom the project depended for counsel and support throughout its course, beginning in the fall of 1967 when

organizational work began. These people and many others—students, school administrators, secretaries—helped with the many little steps which ultimately lead to the project becoming a reality.

Patrick Storey, M.D., acted as liaison between the Division of Regional Medical Programs and the Philadelphia SHO's during the crucial period in May when agreement was essentially reached.

This Report was edited by Jon Snodgrass, Karen Lynch, and Paul Frame.

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Section I

BACKGROUND TO THE PROJECT

Ron Blum

The genesis of the Student Health Organizations in Philadelphia can be traced to the attendance at the Second National Assembly of the Student Health Organizations held in New York in February 1967, of about half a dozen interested medical students from Philadelphia In 1966 the first summer project was conducted in California and two medical students from Philadelphia participated. After the New York assembly, citywide meetings were held in Philadelphia, at which plans for a Philadelphia Student Health Organization were discussed and the prospects for a summer project in 1967 were considered. Though this project did not materialize, local activities did begin, as the SHO philosophy became dispersed to the student bodies. The interest generated at some of the schools waned as the school year ended, but several more students from Philadelphia schools participated in the California, New York, and Chicago summer projects in 1967.

During the summer of 1967, some students who remained in Philadelphia made important inquiries toward establishing a summer project, and promoted with increasing enthusiasm the considerations of such a program in Philadelphia. In September 1967, at a meeting held to report on SHO experiences, an unanticipated surge of interest forced standing room only. Full efforts were thereafter directed to establishing SHO chapters at the Philadelphia schools and directing full strength toward organizing a summer project. A Student Health Steering Committee evolved that made the necessary contacts and wrote and rewrote grant proposals—modeled after the other projects, but with important major revisions and alterations based on the experience and ideas of those on the steering committee, which by early winter was steadily expanding in size. At the same time proposals were being written, many community groups, agencies, and individuals were approached, both as prospective project sites, and in some cases as possible financial resources. Committees worked also in seeking support of faculty members and the deans of the medical schools.

The individuals involved in setting up the Philadelphia Summer Project 1968 attend the six area schools of medicine (one osteopathic), several nursing schools, and various graduate schools, representing a coordinated effort that, in itself, was an experience in interscholastic cooperation. The project was designed to expose health science students to the patient as a social being. At 35 community and agency project sites, 74 students, 21 community workers, and 20 high school interns worked under selected preceptors. The sites were predominantly in lower socioeconomic level communities that included Caucasian, Puerto-Rican, and Negro slums. Placements were selected that had potential to provide a good learning experience while offering students opportunities to develop judgment and initiative in constructive community action. The freedom to direct their activities was left with the project fellows and the preceptors. Summer project staff were oriented to support, not direct.

The philosophy of managing the student health project might best be reflected in part by a brief consideration of the roles and structures involved:

a. The project fellow was a health science student in the fields of medicine, nursing, dentistry, law, social work, pharmacy, or psychology. He worked for a 10-week period.

b. Community workers were individuals who resided in the immediate community of the project site where they were hired to work. They were adults working shoulder to shoulder with students. They served as liaisons with the community and now remain as vital contacts for continued community programs.

c. Youth interns were high school students who fit similar criteria as the community workers. These students worked closely with their health science student counterparts and in the process developed, it is hoped, an interest in health science careers.

d. The project site was the organization, agency, or office where the project participants worked. Health science students were allowed to indicate preference of job site, and dispositions were made on the basis of request whenever possible.

e. The preceptors were individuals, usually professionals, who were responsible for the activities of the project workers (a, b, c) at that site. They met with the workers regularly to provide guidance and assistance if needed.

f. The summer project staff included three student directors, five area coordinators, two research directors, two office staff, and a physician project director.

The part-time project director is affiliated with the West Philadelphia Community Mental Health Consortium, a subsidiary of the grantee, the West Philadelphia Corporation. The project director is also on the faculty of one of the medical schools. He advised the student directors in overseeing the entire project. The student director was responsible for administrative duties and organizational liaisons. The two associate directors coordinated project sites and the educational aspects of the project. The five area coordinators were each responsible for a given number of project sites. They met the workers regularly and served as communication channels to the project office for all personnel.

Multiple means were provided by the project staff for workers to become involved and informed. Weekly meetings were held for groups of 12 to 14 people, led by individual staff members, to consider problems and subjects of interest or concern to the group. These provided an opportunity for workers at different sites to share experiences and exchange ideas. Another major educational aspect planned by the staff and committees of project people were the orientation, the midsummer, and the final conferences. Also, one evening each week for most of the summer, a special program was held for the project participants and friends, bringing in speakers and films on pertinent local and general issues. Throughout the summer various work groups evolved that allowed people with similar interests to consider action in such areas as Summer Project 1969, admissions of blacks into health science professions, the SHO Fourth National Assembly, and other issues.

Biweekly meetings were held with staff, interested project workers, and the advisory council, the latter consisting of four Philadelphia professionals: two physicians, one in city government, and one in medical education, a full-time community organizer and a group trainer. Policy decisions were reviewed and made at these meetings. The staff met weekly also with training consultants who assisted in developing leadership skills and an understanding of group processes.

The goal of the extensive programming for and by the staff and project workers was a total involvement experience. Individuals had the opportunity to pursue any area of interest as it related to community health and their own education. The results of their involvement in the student health project are reflected, in part, in the following pages.

Section II

PROBLEM PAPERS

Karen Lynch

Introduction

Since the Student Health Organization's pattern of sponsoring summer projects and publishing reports of the projects seemed on the verge of becoming an inviolable tradition despite SHO's resistance to adopting routinized, institutionalized activities, the attempt was made to orient the reports of the sites away from a narrative "this-is-my-summer" account toward a more critical issue-oriented examination of the health care delivery system.

Thus, early in the summer a brief outline of plans and expectations about the summer was collected from all the project workers. These reports were then used to distribute three different guidelines for problem papers and one guideline for describing local communities. These forms are included in appendix 4. Each site was different and I ran the risk of asking irrelevant questions of a site's activities.

Yet the resulting articles present a critical point of view on a number of issues which the project workers experienced first hand. In future projects this approach may be used in a more directed way, asking specific questions about specific problems. This summer, however, such an approach would have been totally at odds with the philosophy of the Philadelphia project.

The articles which follow concern experiences with community groups, health and non-health agencies, attempt to solve various health and environmental problems and many other topics. They should be read as cases which present problems and possible approaches to solving them.

STUDENT HEALTH ORGANIZATION IN THE COMMUNITY

What Happens When SHO Workers Step In?

At 25 of 37 sites, approximately 80 project workers were cooperating with local community groups, some "grass-roots" organizations, some settlement houses, and some other types of organizations.

With all of these organizations the SHO workers were planning with the community to do a variety of things. With Pernet Family Health Service, Spring Garden Community Services Center, and Young Great Society, SHO workers were directly meeting health needs. At other sites, for example, Hawthorne, Ludlow, and Hartranft, SHO workers were serving their communities directly by sponsoring recreational activities and leading classes. Others, among them Fairmount, "The Pocket" and Taylor Street projects of University Settlements, and Gray's Ferry, were helping communities attack environmental health problems or community needs.

Others were identifying problems in such a way that other organizations, political bodies, public agencies, and planning boards would become aware of them. SHO workers at Delaware County's Citizens for Better Public Health, Eastwick Community Organization, Welfare Rights Organization, North City Congress, and Southwest Center City Community Council were working on these problems.

Still others were setting up or planning for programs. SHO workers at Mantua Community Planners, Citizens Concerned for Welfare Rights, CEPA (Consumers' Education and Protective Association), Houston Community Center, and Spruce Hill Community Association were involved in designing and getting programs started.

In short, SHO was working with a wide variety of community groups this summer in a vast range of activities.

Out of these experiences a number of different issued were raised. Similar questions were asked in different situations. The most prevalent were these: How can SHO work effectively with local communities? Why aren't health problems priority issues in these communities? What can be done to improve relationships between local communities and health institutions and health professionals?

The three papers in this section describe attempts to work with local communities. The four papers in the next section describe attempts to identify health issues in communities, the problems involved and the explanation for the apparent unimportance of health problems.

The project workers in Gray's Ferry, on Taylor Street and in "the Pocket" were all confronted with similar problems. There were obvious improvements which the communities wanted, but action depended on the approach the project workers and others made. As Richard Bonano and Rhoda Halperin observed as they worked in Gray's Ferry, an independent survey team failed in their community to make use of informal ways of gaining access to community residents. They also noted that community fears and distrust keep some families from cooperating with other families even on the same block.

Action also depended on the spirit of the community to move. The contrast they found between the white community of Gray's Ferry and the black community of Gray's Ferry are clear examples of the consequences of motivation and lack of motivation.

Yet even high motivation cannot be sustained without cooperation where communities need the assistance of, for instance, the Sanitation Department, the Housing Authority, or other agencies. Bill Robinson saw this in his work with Taylor Street residents. The environmental problems there could not be effectively solved without the help of the City Sanitation Department.

Perhaps Art Pressman found one of the solutions to inaction: as an outsider he aimed at personal vested interests of residents in order to build interest in Clean-Up Day at the Tot Lot and interest in preparing a house for the nursery school.

All three of these projects were confronted with the problem of working *with* their communities rather than working *for* them. The project workers built on issues which the communities wanted to work on and on issues which personally affected the residents. It calls for a great deal of sensitive probing and for identification by workers with the community. Looking at these three accounts of attempts to work with communities with an eye for the approach to problems at each site will point out the successes related to working with the communities and the failures related to working without them.

Gray's Ferry, Summer 1968

Richard Bonano and Rhoda Halperin

To those who do not live there, Gray's Ferry is a community located 1.5 miles southwest of City Hall. It is clearly defined and cut off from the rest of Philadelphia by the Schuylkill River on the north, west, and southwest, the railroad highline on 25th Street to the east, and Morris Street to the south. The presence of these natural boundaries provides one with a sense of physical enclosure and thus unity. In reality, Gray's Ferry exists as many social, economic, racial, religious, and ethnic fragments. Each group has its own way of perceiving things, and its own way of doing things. In this sense, Gray's Ferry is not a single community.

While geographical factors act to unify the community on the one hand, geography contributes to the fragmentation of the Gray's

Ferry area. Wharton Street, which runs east-west, is viewed by many members of the community as a barrier which cannot be crossed from the south side by whites, and which should not, although it is, be crossed from the north side by the blacks. The black community is referred to as that area "north of Wharton Street."

The people in the white community "south of Wharton Street," are primarily of Irish or Italian descent. Some of the older citizens can barely speak English; some families have lived in Gray's Ferry for six or seven generations and would never consider living anywhere else. Some members of the younger generation, older teenagers primarily, cannot wait to get out of Gray's Ferry. Practically all the residents are Catholics; most belong to St. Gabriel's Parish. The Church is a highly influential force in the community. Most of the working people are employed in the surrounding factories as welders, placeworkers, etc. There are a few small businesses owned by the residents of the area. Their proprietors are often looked to for advice or funds for the few community projects. Some families own three and four houses on a block. These people consider themselves better off than the majority of people in Gray's Ferry. One lady told us that the reason people kept this property was "to keep the community nice." What she really meant was that the people wanted to keep the blacks and other "undesirables out." "Right behind this block," she said, "is a family who live like pigs." The white community itself, is by no means a single social, economic, or cultural milieu.

The Gray's Ferry Community Council is the official representative structure of community organization. The total membership on the council includes some 400 citizens. The Executive Committee, however, is the main policy making body. It is composed of businessmen, most of the religious leaders in the community and residents, a few of whom are black.

The Community Council has primarily been concerned with the urban renewal and redevelopment which has been planned for Gray's Ferry. A full-time Community Relations Representative of the Redevelopment Authority works with the Community Council. The Council claims to represent the entire Gray's Ferry community on the redevelopment issue.

An additional element in the Gray's Ferry situation is University Settlements. The Community Council originally contracted with University Settlements for social workers to explain the renewal plan to the people north of Wharton Street. The hope of the council was that this would serve to gain the support of the black community for the plan. Instead, the black community has begun to become aware of the reality that their homes have been scheduled for renewal. This means, in essence, black removal. As a result of the realization of the plan's inequalities for the black community, the people north of Wharton Street are beginning to mobilize themselves against it. The black leadership has taken the position that if the redevelopment plan does not change to accommodate their wishes, the plan must be thrown out. This has created a great deal of friction in the community and the Community Council has for the first time been forced to take the demands of a semiorganized black community into account.

The problem of redevelopment, and the general situation in Gray's Ferry has been exacerbated by the requirement for a diagnostic survey of the community's needs. Transcentury Corporation has been contracted with by the Community Council first, to conduct a diagnostic social survey in Gray's Ferry, and second, to relate to the community's immediate needs. Because of the position it has taken as an establishment organization, and because of a series of blunders, Transcentury has been unable to gain the support of the black community. That is, the black community has barred the surveyors from their homes. Transcentury has relied upon the formal structure, the Community Council, without taking into account many informal structures. For example, Transcentury has set up a referral service without taking into account the fact that such a service exists in the community. Transcentury's major fault has been that it has tried to impose itself upon the community rather than to work with community people. Transcentury has set up a series of topics to be surveyed. Some of these are health, employment, and recreation. Education, specifically the issue of the building of a new school in what the community considers to be a dangerous industrial area, is of primary concern to the people in Gray's Ferry. Yet, the survey has no section to deal with educational problems.

Since Transcentury has been unable to gain the support of the black community in carrying out the survey, additional tension between the Redevelopment Authority and the black community has grown up. Action to the benefit of the community has been further delayed. In progress now are negotiations between the various parties involved. The issues have by no means been settled.

It is in the context of this tense situation that some of the problems of community organization and community action must be viewed.

Our decision had been to concentrate our efforts primarily in the white community. However, we soon discovered that this presented us with many unanticipated problems. The most striking of these is the prevailing attitude in the white community towards change and improvement. For example, a pharmacist told us that it would be impossible to organize a group of people on a given block to do something about a particular issue because "no one cared." He agreed that conditions needed changing, but was certain that, in fact, there was little or no chance of implementing change. He was not pleased with the status quo; he merely accepted it and the problems it presented to him on a day to day basis. "People here are lazy," he said. He gave us the impression that a definite inertia existed in Gray's Ferry. People are prone to complain, but do not move to act. In this sense, they seem to accept their fate as it is.

An Italian woman expressed concern to us about the plans for a new elementary school. Her concern, however, was based on the fear that her house might be taken in order for the school to be constructed. The white people in the southeast section of Gray's Ferry, in fact, have formed a separate community council. The purpose of this organization is to oppose the building of the school in their neighborhood. This woman wants the school to remain where it is. "That school has been there for years and years," she said. The school she is referring to is the Benson Elementary School which was built in 1888. Now it serves primarily black children. The presence of a public school in this neighborhood would necessitate black children walking through the Italian section.

That people are primarily concerned about what immediately and directly affects or threatens them is particularly evident in the field of health. Most people in the white community have their own private physicians. When asked about health problems in the community, they usually told us about a relative who had been sick recently. Similarly, the doctors in the community were only concerned with their private patients. When asked about community health problems, responses were: "Well, I can tell you right now mumps are goin' around," Or, "The problems are not here. They are in the clinics."

Our job now was to find an issue which would have a direct, immediate, and positive impact upon at least a few people in Gray's Ferry. We learned that the residents of Earp Street, a small street between 27th and 28th Streets, had participated in a series of organizational meetings to discuss plans for building a play area on a vacant lot on the block. At one time, we were told, the residents had been quite enthusiastic about this project. Now, for a number of reasons, interest had waned and the various authorities involved were under the impression that the people were no longer interested in obtaining a Tot Lot from the city.

It seemed only logical to us, however, that parents would rather have their children play on grass than in the dirty streets. Since interest in the project had been quite substantial at one time, why would it not be possible to revitalize the initial enthusiasm? We were soon to see why there would be no Tot Lot on Earp Street.

It soon became evident that there, too, people were willing to act in their own self interest, and only in their own self interest. One woman said, "Why should I give my time and money when Mrs. X across the street will not. Her children will play on the lot the same as mine." Another great concern was connected with how the residents of Earp Street would be able to prevent the children from "over there," meaning the black children from across 28th Street, from using *their* play lot. There seemed to be no understanding or acceptance of the idea that action which would be in the interest of the entire community would also benefit one's own self interest.

In fact, to the people on Earp Street, the use of the lot by "outsiders" posed a threat to them. What would they do if a fight occurred on the lot? Who would be responsible for breaking it up? Who would be responsible for keeping it clean? The fact that the city would provide the facilities if the residents would take on some responsibilities for taking care of them was incidental. The people wanted the authorities to take care of everything, or nothing at all.

The Tot Lot was voted down by the residents of Earp Street. Given the racial situation and the attitudes of the people towards change, positive action was virtually impossible.

At the Vare Recreation Center, located in an Italian neighborhood, we were to see an instance in which people will move to eliminate that which is negative or detrimental to them, but will not tax their energies to create the positive. Programs at Vare are designed to keep kids off the streets, not to provide new, creative activities. The staff hired by the Department of Recreation run everything. Those in charge find sufficient gratification in containing the youths within the confines of the recreation center. It is great for rough teenage boys to sit and play cards all day. This keeps them out of trouble.

We have sensed a different attitude towards change among many of the black people we have met. Although they are not militant, many clearly have decided that certain things will not be accomplished in their community unless they do it themselves. They will not accept the premise that "the establishment" will do it for them. In fact, they have come to distrust establishment organizations.

A segment of the black community successfully organized and carried out a clean-up campaign in the area north of Wharton Street. The designated purpose of this effort was not simply to clean the street, but to develop a sense of unity among the people and to get people together for the purpose of confronting the establishment. The press was there to witness and report that these citizens had cleaned the streets and were in the process of sending the city the bill for the job the Sanitation Department was supposed to have done.

The youth of the community dealt with the establishment, in this case, the Department of Recreation, by avoiding it completely. A group of black youths rented a garage to house their own recreation center. They are very concerned about doing constructive things for "the fellas" who have nothing to do in the evenings. They are not afraid to attack monumental problems with imaginative solutions. A group of the teenagers set up a film program which they run themselves. In addition to securing the films, this project involved printing leaflets to advertise the program, obtaining chairs from a church, and selling refreshments to replenish funds. People in the black community have also realized that the so-called establishment can be used to their own advantages. In direct contrast to the inaction of the people on Earp Street, a group of black residents, after one meeting with the people from the Department of Licenses and Inspection, began to collect money for their play lot. Children from the area were consulted with regard to what equipment would be put on the lot.

On a somewhat larger scale, the community's desire to move on its own is manifested in the formation of the King's Village Association in a section north of Wharton Street. This group has helped to stir people out of their apathy towards accomplishing meaningful social change.

These attitudes toward change have largely determined the course of our action in Gray's Ferry. We had originally been contacted by the Community Council to strengthen the Health and Welfare Committee, with the hope of eventually setting up a health center in Gray's Ferry. We soon learned, however, that to strengthen the Health and Welfare Committee was impossible on several counts. First, this committee did not exist as a functioning body. It hardly even existed on paper. Second, the community had other priorities. Because the people were concerned about their homes being demolished by the Redevelopment Authority, there was little interest in establishing such a committee.

We then discovered that, although recreation was not such an urgent concern as urban renewal, it did represent a concern of the community which held higher priority than health. Our task was to find someone or some organization in the community with which to work. Fortunately we have been able to work with a black woman who is probably the person most concerned about the activities of the community's youth. Her activities reach far beyond her responsibilities as director of the Summer Urban Day Camp. One of her chief concerns has been lack of indoor space which is essential for carrying out a winter program of any sort.

We became aware of the urgency of this need, and realized that the city agencies could not be relied upon to furnish this space in any reasonable amount of time. With the community people we began to investigate other ways to obtain space and facilities.

We were fortunate enough to be given the name of a socially minded architect who would work with the community people. He willingly offered his services in drawing up plans for a cost estimate on a new center for Gray's Ferry. Our idea is to take his plans to private industry with the hope of finding a sponsor for the project.

In the meantime, we have obtained a vacant building on the corner of 30th and Wharton Streets to house the Gray's Ferry Workshop, as it will be called, on a temporary basis. Evidence of community support for this project has taken many forms. One businessman in the community has donated a kiln for ceramics and paid for the first month's rent. A group of youth have planned a paint party and general fix-up weekend. Attendance at planning meetings has been extremely good.

Our aim with this project, from the beginning has been to help the community set things up in such a way that they would in no way be dependent upon us for the project's continuance. We have tried to act as a stimulus to the people so that they would respond in an active way to their own needs. Now they are beginning to become aware of and use resources outside of Gray's Ferry.

We believe that any project of this sort must be initiated, planned, and carried out by people from the community. Outsiders, like ourselves, can be most effective as advisors and as resource people. To go to a community with the idea of doing things *for* and *to* the community rather than *with* the community would probably prove to be highly detrimental and possibly disastrous.

1400 Block, South Taylor Street

Bill Robinson

The 1400 block of South Taylor Street is a single block in South Philadelphia. The residents are all black and generally of low income. Most houses are rented. Approximately five to seven are owned by residents. Five houses in the block are vacant. The street is very narrow. The residents have a large number of teenage and pre-teenage children.

Services to the Street

There is no public transportation through Taylor Street or on adjacent streets, but it is fairly accessible to residents.

Shopping and schools are also not immediately available, but they are accessible without major inconvenience.

Rubbish and trash are collected once weekly on Monday (usually in the morning). The major problem for residents is the failure of city workers to clean alleys of trash and garbage.

Police protection is adequate, at best. Residents generally do not hold police in high regard. Police are slow to respond to residents' calls.

Recreation is another major problem for concern of residents. A public square is approximately one block away but parents feel the area is not safe for their children. Parents have tried unsuccessfully to get a vacant lot in the block converted to a Tot Lot. No other facilities are available. Children play in the street.

Residents have little concern for the health care system. They prefer to concentrate on realities of: (1) No play area for children; (2) danger of traffic to children playing in street; (3) fire hazard from children playing in open vacant houses; (4) rats in homes; and (5) trash accumulating in alleys.

The major community health problems is the social well-being of the block residents. Problems associated with their environment have been under primary consideration. In light of this, the Taylor Street Residents Association has been working on all of the problems described above.

When the people of the block have decided to act on a problem, they: (1) Decide on a channel for action; (2) contact city official or other power and register complaint by phone and/or letter; (3) repeat action if needed; (4) contact Congressman William Barrett for assistance for the city related problem; (5) consider other actions if needed.

Environmental Problems

The central movement of the Taylor Street Residents Association was a multi-faceted attack on problems associated with their environment. From the health standpoint, their aim was to improve their own social well-being by acting on their own community. This was the position presented to me by the residents themselves. They wanted to take action in the specific areas described below, and wanted me to help them.

One major area of concern for the residents was to try to convert a vacant lot on the block into a Tot Lot, on which their children could play. Contacts were made with the Department of Recreation, Land Utilization, University Settlements, Congressman William Barrett's office, et. al., to attempt to achieve this.

The stumbling block was presented when one of the property owners, Mrs. X, said that she could grant permission for the group to use her property if she were insured against any liability charges from parents whose children might be hurt playing on the Tot Lot. Attempts to seek this insurance through the City of Philadelphia, University Settlements and others were rebuffed and the action has been stymied.

At present the property is tax delinquent according to Mr. M. of the city's Land Utilization Office. In this case, the land will be placed available for sheriff's sale in approximately 8 months. At this time the city can purchase the property and effect the conversion to a Tot Lot. A major consequence of the delay through "red tape" and negotiations has been waning interest and skepticism on the part of the residents that anything will improve their situation.

Another situation which the residents saw as a problem was the fact that although the street is very narrow, at various times of the day, it has a high degree of car and truck traffic. This presents an obvious danger to the large number of children who play in the street. They attempted to get signs reading "No Through Trucks" and "Slow, Watch Children."

The presence of five vacant houses in the block has caused more concern for the residents. They had become depositories for trash and garbage for people from other neighborhoods, and thus havens for rats. But more important to the residents, they were open invitations for children playing with matches. Many fires had resulted in previous months and years.

This problem was presented by letter and phone calls to Mr. S. at the Complaint Department at Licensing and Inspections at City Hall. After many months, only one of the five houses has been properly cleaned and sealed. Again the residents have talked with feeling that this attitude prevails because they are black.

The final major problem voiced by the residents concerned the presence of rats in their homes and backyards and the accumulation of trash and garbage in their alleys. The rat problem seemed to be caused or at least enhanced by the trash problem, so emphasis was placed on removing trash and garbage. A representative from the City's extermination unit was contacted, but he felt that it would be futile to place poisoned bait where rats had so much other debris and food to eat.

At least ten complaints and probably more were registered with the Mayor's Office for Complaints because the City's sanitation workers would not clean the alleys. The alleys were last cleaned on approximately the first Monday in June. Since then they have become deplorable. It is a fact that the people of the block could clean the alleys themselves, but again it is a point that their taxes help pay for this service and if they were more affluent, or *white*, they would not have to be subjected to this treatment by the City.

The concern of the residents of Taylor Street for their own improvement, through uplifting their environment, has been suppressed. The City has shown in various areas to be impersonal and unresponsive to their needs. They have gone "through proper channels" to affect changes, but the results have been negligible.

Their interest in helping themselves is waning, as their confidence in those who make change is reaching a new low.

I identify very closely with the residents in general, and have not, and will not try to console them or attempt to reconcile them with the systems of the "establishment." If someone with a more militant approach revives their interest in helping themselves, they will be much more receptive to an attitude of "damn the establishment!, we'll change things our own way!"

The Pocket

Art Pressman

"The Pocket" is the area within Taney Street, Webster Street, Catherine Street, and South 26th Street.

This is an all white community. One black family was driven out about a year ago. Once mostly Irish, now some Italian, but still overwhelmingly Irish, most men work at Philadelphia Electric, half a block away. There is a large incidence of interrelation among families. Many residents have lived their entire lives in "The Pocket." A few are really large families with eight or 14 children but most families have about three to four kids. One very rarely sees any teenagers, therefore the impression exists that only young children are around, but teenagers mysteriously surface in the evening. Most people marry from within "The Pocket." It is rare for someone to bring a stranger in (stranger: more than 10 blocks away). "The Pocket" is completely surrounded by black communities. There are no other whites for blocks. There has been hostility for years with the power shifting to the blacks more and more every year. Eight vacant houses stay vacant; no one wants to move into "The Pocket." Their most difficult problem is realizing that they live in a poor white ghetto.

"The Pocket" is convenient to public transportation; garbage collection is regular; South Street "business" district is very close; there is a swimming pool at 26th and South (in terrible shape, and the community is disgruntled about the Marian Anderson Center being so nice); University Settlement House has day camps, day schools, a gymnasium, etc.; St. Anthony's Parish has a school; there also is a public elementary school, but pupils there are mostly black; most Pocket children go to St. Anthony's. Police protection is good during the day, but there are complaints of its being almost nonexistent at night.

Since most Pocket women are Catholic, one would not imagine many to be practicing birth control, but most are. Three blocks from the Hospital of the University of Pennsylvania and Philadelphia General Hospital, the people use the clinics quite often. St. Agnes Hospital is also frequented. No complaints were heard of these institutions other than waiting time and the Filipino doctors who don't understand what is wrong with the people.

There has been almost no community action. "The Pocket" expects the community organizer to do everything. They sit and talk, but are mysteriously absent when the time comes for the work to be done. This sounds presumptuous but I just spent today trying to round up 45 men to work for two hours this weekend in the nursery and got a most negative response. At this stage, the next thing to do is incense the men individually about their collective weakness. Maybe some will come out that way. The women are fairly industrious—some are notorious laggards, others are bundles of energy.

Before anything can be accomplished in a community, the community must desire the end result. For an outsider to enter a neighborhood and identify and remedy certain problematic conditions is a condescending gesture. Certain circumstances cannot equal a problem *unless the community sees a problem from their perspective.* No doubt many conditions exist in the pocket that warrant immediate attention, but I feel that it is not my place to identify them. This is not to say that I blissfully ignore them. Questioning of a random nature during a friendly conversation generally produces one of two possible results. "How long have those three abandoned cars been on the block?" "Two years" or "Two years . . . I sure wish we could get rid of them." If the people affected by the problem recognize it, then the community organizer and the community reach the first plateau—a problem exists. Without this recognition, the community organizer is nothing more than an officious intermeddler.

Once there comes this recognition and, therefore, identification of the problem as their own, the mobilization of the community into some form of functioning political entity can be attempted. (N.B., *attempted* rather than *accomplished.*)

The organization process is the most difficult. The two major issues of the summer helped facilitate this process in that both issues affected a major part of the community. A digression into the background of these issues is necessary at this juncture. *In conjunction with University House and the community, the Land Utilization Department of Philadelphia constructed a Tot Lot last fall.* Reread this sentence because here is where the basic problem lies. The community did not construct, but Land Utilization constructed. Certainly men and women of "The Pocket" contributed valuable man hours of labor and certain materials, but the end result was not "The Pocket's" project. The fact that the Tot Lot resembles a first year architecture student's nightmare, which indeed it turned out to be, does not matter. Merely, this project, because of the great stake the City of Philadelphia had in it, was not allowed to fail. By this I do not mean to imply that it was a success—not at least to the people in "The Pocket." They use it, play in it, and gather in it, but it is almost as if they have borrowed it from someone else. For Land Utilization it was a success, but, alas, only a hollow one ("The Pocket" strikes back!) Within the space of six unattended months, the Tot Lot became a mass of broken glass and litter. No community responsibility existed for its condition and indeed, none should have for the Tot Lot did not belong to "The Pocket."

Once "The Pocket" recognized the hazard the Tot Lot presented, we were back at the organization process. No strong leadership exists in this neighborhood, as I am sure it does not exist in many other ghetto areas. Many reasons for this exist—general complacence, the individual's desire to drink his beer in peace, and lack of confidence to lead, much less influence, the opinions of others. If one is able to overcome these obstacles, another more serious barrier presents itself—the community's reluctance to accept anyone as their leader. "The Pocket" resembles a petty duchy in that self-appointed kings are constantly being deposed. Even if a leader is "democratically" elected by the community, the community refuses to look upon him as a leader. Distrust, envy, and backseat driving immediately set in. A feeling of community is the only alternative to the leader problem. This can be accomplished through total involvement of the entire group in an issue with pointed relevance to all. The Tot Lot was one of these. By making the Tot Lot's condition each person's problem, rather than the vague general community's problem (and therefore no one's problem), we were able to wage a successful campaign to clean up the Tot Lot. "When's the last time your child cut his foot in the Tot Lot?" "When's the last time your neighbor's kid came into your home and bled all over your rug, because no one was home at his place?" is effective rather than "Let's clean it up because it's a mess." One must touch each person's vested interest, whether it is his child, his rug, his hatred for the sight of blood, to mobilize a group of individuals into a functioning body. There was excellent attendance on Clean-Up-Day and heretofore disinterested persons took an active role. The beauty of this project was that it was a one time affair—the lot has remained in excellent shape for 6 weeks now. One lady hoses it down every other day or so and takes care of the hose that operates the sprinkler for the kids. Because of their involvement in the initial clean-up, the mothers, when present, impress upon the children the need to keep it clean. Play-Street, a University House afternoon recreation project, also instills this attitude. For a period of about three weeks after clean-up day, the mothers took turns supervising the lot, keeping out the bottle breaking older kids, and watching out for the safety of the younger ones. While it lasted, this scheduling of mothers was very effective, but its breakdown is directly linked with issue No. 2—the nursery school.

The University House and "The Pocket" had long considered opening a nursery in "The Pocket" for the Pre-schoolers. University House negotiated for a vacant house and had an option to buy the building. The Board of Education had promised to furnish a teacher and some equipment, if the school met their standards. Through a raffle, "The Pocket" was able to raise about $100 that acted as consideration for the option contract. Paint was purchased and the community began to fix up the building, which was in a state of terrible disrepair. Scrubbing on hands and knees came first and the women eagerly pitched in and the place began to take shape. It was looking too good to be true and was. The Board of Education required a minimum of 18-20 children enrolled for them to sponsor a school and provide a teacher. Since "The Pocket" is teeming with children, no one had ever considered the possibility that maybe "The Pocket" could not come up with enough children. After long arducus searching, we only came up with 16. The big question was where would others come from. If two more children could not be found, the nursery would fail. Because of its unique position in relation to the surrounding community, "The Pocket" was in the hole. "The Pocket's" unbelievable antagonism for their black neighbors surfaced when we asked them to consider the possibility of getting the other two children from the adjoining neighborhoods—all of them black. Spoken to individually, a scant few of the mothers who had already enrolled their children in the nursery indicated that they would have no objection to an integrated school. Even though we described the nursery in terms affecting their interests, i.e., getting rid of the children five mornings a week as well as improved educational backgrounds and easier adaptability to the first grade, the community acted in accordance with their emotional needs. At a community meeting with 100 percent attendance, the unanimous decision was . . . no nursery of black children. To circumvent the problem, rather than drop the entire plan for the nursery, the community developed their own options: get the Board of Education to lower the limit of children to be involved; rent a building from University House and staff it with mothers; have University House extend the geographical boundaries that the nursery would service in order to take in areas with some white children. No one really worked on these options and work on the half-painted school stopped. Tot Lot supervision also ceased as a sort of protest. "Lethargic limbo" was where "The Pocket" found itself. We made it clear that in no way would we help to segregate the nursery. Discrimination by geography was one thing—only people from within the boundaries were eligible—but we would not support any other type. After about three weeks the mothers decided—with the empty half-painted school on their block serving to remind them of their foolishness—that something really ought to be done one way or the other, so a meeting took place. Somehow they miraculously came up with three other children from within the boundaries; independent action on their part because they finally realized that they really wanted the nursery. Or did they? Whatever the answer, work begins anew on Monday and hopefully the school will be ready to go by the middle of September.

These two projects, the Tot Lot and the nursery, were the major issues of the summer; but in order to substain overall interest, numerous secondary, easily remedied issues were worked on. Boarding up a vacant house, fixing the fireplug that had eroded half the street, and having one vacant house condemned provided a type of day-to-day incentive system that kept the community's interest intact for the major issues.

HEALTH—A PRIORITY ITEM?

At a few of the sites this summer, *project workers were asked by their sites' organizations* to conduct surveys or investigations into the health needs of their communities. The startling result of these investigations is that health is not a priority item. Although the SHO workers began by asking about health needs, environmental problems and recreation were more visible and more urgent issues than health problems.

In this section the process of setting up the studies, the results of the studies and the consequent action at four sites is presented.

The first article about attempts in Ludlow to set up a community blood bank, teach sex education classes, and show a cancer detection film points out the fact that health problems *are obvious,* but they have to be met in the order of their priority to the community. If you are faced with rats, shabby housing and unpaid food bills, as Jerry Braverman points out, you haven't got time to worry about cancer, give blood, or learn about sex.

Both Eastwick and Paschall community organizations requested a survey of their neighborhoods in order to gather evidence to bring to bear on government authorities and also to identify for themselves where the needs and priorities of their community were. Unlike the report from Ludlow, the results of surveys in Eastwick and Paschall indicate that their real health needs are not as fundamental and basic as the needs found in Ludlow. Attention was placed on recreation facilities in Paschall and on a variety of environmental problems in Eastwick. These findings suggest that it is very difficult to deal with the underlying health problems in ten weeks and that attention is likely to be diverted to easier projects like recreation programs, blood banks and visible environmental health problems. The basic, underlying problems are obvious to residents and those concerned with meeting health needs, and they are vast. Concern for the less visible problems of cancer and other chronic diseases can only be stimulated and can only interest residents of these communities when other more pressing needs have been met.

The final report in this section describes the experience of SHO workers who provided technical competence to the Welfare Rights Organization in designing a survey at WRO's request, training WRO members to do the surveys, and then examining survey results.

These experiences suggest that health needs are obvious and pressing. Communities' priorities are also obvious, even though it may take unsuccessful programs to show it. Health service producers must be aware of community demands and meet these in order for their programs to be effective.

Complex Problems in Ludlow

Jerry Braverman

The Ludlow community extends from Girard Avenue to Montgomery Avenue between Fifth Street and Ninth Streets. It is approximately 50 percent Negro, 40 percent Puerto Rican, and 10 percent White; it has been described as one of the ten worst slums in Philadelphia.

The health problems are obvious, most of all to those who live there, and any program which does not directly attack these problems is destined to meet with limited success. Our basic programs, sex education and blood bank, are prime examples. Although worthwhile, these were indirect efforts to remedy some comparatively minor community problems, and consequently, did not stimulate any community support.

A more illustrative example was our attempt to show to the women of Ludlow a short film concerning breast and uterine cancer. Despite leaflets, posters, sidewalk solicitation and announcements in the local churches, only three or four women showed up.

They do not have cancer now and are not worried about it; they have never needed blood in the past so why give now; academic matters about sex do not interest them. NOW are rats, shabby, overcrowded housing, and food bills.

Further, I do not feel that a SHO person should initiate an attack against these problems. They are the problems of the people who live here, and when these people come to recognize these themselves as community problems (without having been told) and begin their own action, then would be the time to enter with funds and personnel to provide impetus to their movement.

Our problem is a complex one and I do not have an answer.

Eastwick Survey Report

Paul Frame, Bill Woods, Andrea Benn,
Renee Edwards, and Eileen Fair

The Eastwick Community Organization is a fairly new organization. The Eastwick area has been an urban redevelopment area since 1958. A large number of families have moved from the area and public services have diminished since then. The Eastwick Community Organization felt that a survey could better determine the needs of the community and could be used as a working paper to get better service into the area.

The survey is to be used by the Community Organization to put pressure on various agencies and institutions, especially City Government and the Redevelopment Authority. The survey was commissioned by the Community

Organization and the survey committee of the organization is in charge of carrying it out. A community worker with the Methodist Service Center who works in the Eastwick area is also interested in the survey and has been working with us on some of the individual followups. The Community Organization received a grant from the Philadelphia Council for Community Advancement which allowed them to hire a community resident, Mrs. T., to work with the SHO students and survey committee on the survey. This grant also paid for the incidental expenses of the survey.

The actual survey was drawn up by several people, including Community Organization members, SHO workers, an urban planner working with the West Philadelphia Mental Health Consortium, and a community worker with the Consortium. A rough draft was formed from a list of problem areas the committee thought important to work on. Subsequently there was much of the cutting, rewriting, and changing which goes with preparing any finished paper. The final version contained questions on demography, mobility, health needs, employment, and social and physical environmental conditions. The final version had to be cut down from a 45-minute questioning time to a more workable time of 25 minutes. We tried to make all our questions ones which could conceivably lead to meaningful followup and eliminate those which were of purely sociological interest.

Our aim was to survey as many of the 500 homes in the area as possible. One week in advance we distributed flyers to each home describing the organization and explaining why we were doing a survey. This advance publicity proved to be very important as it alerted people to our presence and we were not total strangers when we knocked on their door to interview them. In general, people reacted cooperatively or apathetically to us. A few were suspicious, thinking we were from the city or the Redevelopment Authority, and of course there were a few refusals and hostile people. Our refusal rate, however, was less than 10 percent. One problem which is common to any survey attempting to reach a total population is that some people are not home when called on and cannot be reached. We usually tried to visit a given house twice in the daytime and twice in the evening before writing it off as "No Answer."

Survey Findings

We are presently in the process of evaluating the survey findings. Some of the main problems which have developed are:

I. Problems caused by redevelopment.
  A. Lack of stores in the area.
  B. Weeds which have not been cut in many fields. This poses a traffic and rodent hazard.
  C. Poor public transportation.

II. Problems the city should deal with.
  A. Lack of mosquito control.
  B. Lack of an adequate sewage system.
  C. Lack of street repair and cleaning of gutters.

III. Problems peculiar to the Larchwood Gardens Apartments.
  A. Bad relations with the landlord.
  B. Noisy kids in the nearby schoolyard at night.

It will be noticed that health problems are not included. This is partly due to the fact that other problems are more pressing and also because the health problems which do exist are individual problems and were handled on that basis.

The survey was useful in determining the overall and specific needs of Eastwick. The subsequent follow-up has taken two basic directions: helping individual members where help was needed, and attempting to strengthen the Community Organization and help it deal with the Redevelopment Authority and City Government.

The first of these directions has probably involved the most successful part of the summer. Needs of specific persons were identified as the survey progressed and handled on an individual basis. For example, several recipients of public assistance were informed of a program whereby they could obtain much needed dentures free of charge through the University of Pennsylvania Dental School, and two have actually begun to be fitted for dentures. Several persons in need of financial help were found eligible for Pennsycare and Food Stamp Programs. Other persons seeking jobs were directed to various training centers throughout the city. One man who lived on the fringe of the community was even helped in his effort to obtain a telephone. It was surprising to discover how many people in the lower income brackets had no knowledge of the many programs available for all types of assistance, and we gladly supplied the needed information. We are presently preparing a "Where to turn" type booklet for general distribution in Eastwick as a continuation of this effort.

The second part of our effort, that of attempting to form a more effective Community Organization, is presently the concern of the community. It is an important issue because the community is in need of an effective force to handle its many problems—mainly public transportation, more stores, effective mosquito control, street repairs and dealing with the Redevelopment Authority. The Redevelopment Authority began its operations in Eastwick over 10 years ago and has planned the project so that it is the largest urban renewal site in the country. However, due to ineffective planning Eastwick today has many overgrown fields where homes have been torn down but nothing has been built to replace them. Also, Redevelopment has not always dealt straightforwardly or fairly with the residents of the area.

The problem of forming a strong, representative Community Organization is a primary problem since it is the community, and not outside SHO workers, who should be dealing with the City and Redevelopment Authority. It is also a difficult problem. The present organization has a nucleus of dedicated people but does not have the widespread participation it needs. Many people are quite bitter over the events of the last 10 years. They stood up and were "bulldozed over" by redevelopment once and don't feel like standing up and being run over again. In Larchwood Gardens Apartments, the people are more transient and many don't feel they have enough of a stake in the community to get involved.

The survey was itself a first step in the attempt to strengthen the Community Organization. The confidence of many people was gained in the process of door-to-door canvassing and a fair number of people showed a willingness to work with the organization. The next step includes the planning of a cook-out and community get-together. The SHO workers will also work with the Organization to obtain better mosquito control, set up a possible sex education course, and assist where we can in further dealings with the Redevelopment Authority.

Other than the problems already discussed above, no major health deficiencies were found. The most pressing problem would probably be the general lack of periodic checkups. Most people are either quite healthy or have adequate health care. One area in the health field was improved, however. It was discovered that a receiving ward type of clinic was recently established by St. Luke's Hospital at International Airport only 8 minutes from the center of Eastwick. The community, however, is unaware that this facility exists. Plans are being made with St. Luke's to publicize the clinic and there is also a possibility that it can be used as the site for a Public Health Service Clinic in the future.

Report on Community Work With the Paschal Betterment League

Renell Burden, Larry Budner, Dudley Goetz, and Chris White

Our major concern at the Paschall Project site was a comprehensive survey of the neighborhood, made at the request of the Paschall Betterment League. Problems concerning health care and municipal services were covered in the study. With demographic material and attitudes toward the neighborhood included, the survey was undertaken to determine whether the residents had any interest in their community and what specific community problems exists.

As a result of the survey's findings, many problems concerning environmental health were made evident. These included lack of: street lights, traffic lights, fireplugs, recreation, a day care center, adequate police protection, and adequate shopping facilities. In addition to the above, abandoned houses, inadequately functioning sewers and unfit housing conditions were reported to the respective city agencies. No significant personal health problems were brought to light, however.

The Paschall community is roughly bounded on the East by 63d Street, on the South by Grays Avenue and on the North and West by Cobbs Creek Parkway. This community is quiet, lower class (and some middle class), and integrated, although mainly black.

Generally, community services, except those pertaining to shopping and recreation, are considered adequate by the residents. Trolley route 11, running from Darby through Paschall to Center City, is the only direct transportation into the city. There were relatively few complaints about the No. 11 in our survey, but frequently of service is significantly lower than other nearby lines. Municipal response to residents' complaints about city services appears to be prompt and at times efficient. There are two hospitals in the area, Mercy Douglas at 50th and Woodland, and Misericordia at 53d and Spruce. These hospitals appear to be used by the residents only in case of emergency. For non-emergencies and/or for sustained treatment, the residents go to the Hospital of the University of Pennsylvania or the Philadelphia General Hospital. Although the neighborhood borders the city limits, very few residents travel into Darby, a nearby suburb (literally across the street) for hospital or clinic care. A large number of respondents in our survey said that they go to their private doctor or dentist for treatment. This response cut across economic, racial, and age lines. The use of public transportation for obtaining medical care is time consuming but reliable (except when snow falls, then the No. 11 doesn't run regularly). One respondent complained about the necessity of taking three buses to travel to a public clinic. There are almost no taxicabs cruising in the neighborhood. Over half of the respondents said they did not own a car.

The major community health need that we encountered is the lack of recreation facilities in the area. Both a large number of small children in the area and the adults suffer from "nothing to do." This deficiency includes a lack of: swimming pools, athletic fields, and equipment and recreational centers.

Both Mercy Douglas and Misericordia Hospitals have very poor reputations in the area. Several residents have accused the hospitals of various forms of malpractice and poor service, such as a car accident victim dying in the hospital because of too long a wait for a needed operation. There is no community involvement on the planning or administrative boards of any health facility in the area, that we are aware of.

In order to obtain immediate community services from the city, we: confer with the Paschall Betterment League President, as to whom in the City Bureaucracy to notify about the problem; call up other voluntary groups, such as North City Congress; and work through the City's published reference guides to municipal departments. After a phone call to the appropriate city office, most of our requests are followed up by a letter to the same office and a copy to Mayor Tate. Complaints by the neighborhood residents were also obtained in the PBL's storefront office. The two project fellows and two students aides assigned to the Paschall Betterment League, 7039 Woodland Avenue, undertook a survey of the Paschall neighborhood at the request of the PBL president. The survey site had been selected on the basis of PBL's conception of its "neighborhood." Of approximately 500 families, 195 families were selected and interviewed during various times of the day. Supervision and "overall responsibility" for the survey remained with SHO students.

The PBL president considered the survey a necessity in order to provide estimates of the neighborhood population density; child population; knowledge of PBL and any other neighborhood organization; "pressing" neighborhood problems; complaints about city services; racial composition; age composition; mobility; number and types of dwellings; employment histories; and neighborhood development possibilities. The large number of questions on health care and services were of less interest to the PBL.

The survey design was not drawn up by either the SHO staff or PBL but came from an outside source. The PBL president added a page of questions to the schedule. Each SHO staff member tabulated his own survey responses in conformity with a master schedule devised by the entire staff. Many questions were discarded as being either too inconclusive ("How much money did you spend on clothing in the last 6 months?") or of little value

("What does the word neighborhood mean to you?") Some of the statistics are being used in a day care center proposal being written by the SHO staff.

The large majority of the respondents were quite responsive to the survey takers. The survey demanded at least 20 minutes of the respondents' time. The noncooperators tended to be older, white, long-term residents who appeared to distrust any individual or organization connected with their changing neighborhood. The area residents tend to be poor and black, although poor whites continue to move into the area.

By far the main finding was the residents' desire for recreation facilities for their children. At this time, the few recreation sites are quite overcrowded, inadequate and beset by racial tensions.

Other problems, but which were not as universally cited as recreation, included lack of shopping facilities and transportation and the need for a Child Day Care Center. Although over half of the respondents were aware of PBL's existence, very few were members. Only 15 percent of the respondents wanted to live "in the same area."

After the survey was completed, SHO staff members began to attempt to obtain needed city services for the area. Attention was drawn to these needs by the survey respondents and noted by the surveyors, although emphasis was not put on the reception of complaints by respondents. On the whole, municipal reaction to SHO requests, made in the name of PBL, was quite good. However, with the SHO staff's assistance, the Paschall Betterment League, has begun action on the need for recreation sites.

Welfare Rights Organization

Marpha Crafton, Shirley Fischer, Gene Schatz,
Jon Bonano, and Jean Wilkerson

The central issue with which we have been concerned this summer is the power of consumers to affect the services they are receiving. This is a central issue because the welfare system, as it presently functions, is inadequate and insensitive to the needs of the consumers, the recipients. The present welfare grants do not provide adequate money for the basic needs of life. Provisions in welfare regulations, such as that which states the recipient must pay back all of the money "loaned" to him by welfare when he finally gets off assistance, stifles motivation to become independent. But even more central to this issue is the fact that the people who administer and deliver welfare services cheat, insult, degrade, or simply don't care about the people receiving the services.

These and other indignities were identified by the consumers themselves. The central issue is how these consumers have been effecting changes in the services they are receiving. They have done this by banding together in a self-controlled and directed group, independent of the influence of nonconsumers. Utilizing publicity and political and legal sanctions, they have attacked the structure which holds up the welfare system.

The Philadelphia Welfare Rights Organization (PWRO) is a truly grassroots organization of welfare recipients. The SHO's relationship to the organization was to help WRO in their fight against the Department of Public Assistance. We were well accepted as helpers and extra staff people.

Our first activity of the summer was to conduct a cost of living survey. The PWRO asked the Student Health Organization to help them construct, administer, and evaluate a cost of living survey. The survey's purpose was to determine the actual cost of food, clothing, and shelter as compared to the allotments recipients receive from the Department of Public Assistance. In addition to the food, clothing, and shelter items the survey included items such as furniture, home upkeep, personal care, educational and recreational expenses. The results of the survey will be presented in Harrisburg to the Governor and members of his cabinet. It is hoped that the Public Assistance payments will be raised from their present level of 71 percent of the 1957 standard to 100 percent of 1968 standards.

The questions to be used in the survey were determined in the following way. The SHO students prepared a preliminary questionnaire. This preliminary questionnaire was presented to the 18 local chapters of PWRO for their corrections and revisions. These revisions were incorporated into the final survey. On Monday, July 16, and Tuesday, July 17, a training session was held for the 18 community workers who would administer the survey. The first training session consisted of reviewing the questions to iron out any last minute problems. The second training session consisted of a trial interview. The 18 community workers were split into teams of two — one interviewer and one interviewee. In the afternoon the roles were reversed. In this way a thorough familiarity with the survey was obtained.

Each community worker was responsible for interviewing 11 people. These people were to be taken from the following categories of Public Assistance, seven Aid to Dependent Children, two Old Age, one General, and one Disability. This distribution corresponds approximately to the percentages given by the Department of Public Assistance. A total of 216 surveys were distributed. As of now (August 14) about half have been returned. About 20 percent of those surveys returned were incomplete, i.e., one or more vital questions were not filled out completely or correctly.

The only difficulty expressed by the community workers was the problem of obtaining people for interviews in either the disability, old age, or general assistance categories. The interviewers have reported very cooperative responses from the people that they have interviewed.

At the present time no analysis of the data has been undertaken.

After the survey was launched our main function was to assist the organization with some of their other activities. The main one was helping the women staff WRO booths in the district Public Assistance Offices. The recipients have a right to be represented by anyone they want when they go down to the Public Assistance Offices. The women assumed the role of client advocates. The reaction of the establishment was both hostile and abusive. Their main objections were that while they were being checked by the women they could not function properly. A great part of the summer was also spent sitting around the WRO office, learning the problems of a grassroots organization. These were problems of building and arousing a membership, keeping outside institutions and groups from influencing the organization, and just simply intraorganizational disputes. Much experience was gained from the consumer viewpoint. This, we think, by the students in battling the establishment has been a valuable experience for future dealings with the medical establishment in the role of patient advocate.

COMMUNITY—"ESTABLISHMENT" RELATIONS

Karen Lynch

Where there is concern and action by local communities to improve neighborhoods and by individuals to make use of available health services, the "establishment" must respond with similar concern and action. Effective response by hospitals, city agencies, and clinics today, means changing from present procedures and adopting new philosophies and programs and even new goals in light of changing needs and priorities of individuals and communities.

The six articles in this section present experiences, problems, insights and potential solutions to community-establishment relationships.

The project workers at Fairmount were confronted with much "red tape" in working on problems of abandoned houses and in trying to set up discussions of family planning. Their experience points out the problems and the inability of communities themselves to straighten out communication paths from neighborhood to City Hall, to the Bureau of Licenses and Inspections, and with the Board of Education. Solutions to these problems must come from the agencies themselves.

Solutions are being suggested for another problem of the resident of the inner city. Steven Marder's investigation of the adequacy of pharmacies to meet the needs of poor people pointed out the pressing need for young pharmacists and the possible ways of meeting this need. The article printed here is an abstract of a much longer, more detailed report which he prepared during the summer.

The remaining articles in this section deal with the difficulties of providing service within large organizational structures. Differences in philosophy between the Day Care Program of the Temple Community Mental Health Center and the Department of Psychiatry at Temple

Medical School led to strain in running that program. "The Saga of Fidel Cruz" shows vividly how one man "battled" with an ear, nose, and throat clinic and will never return. A few incidents like this one may result in an entire community losing trust in the clinic. The proposed position of patient advocate at Presbyterian Hospital, reported by Frank Greer and Jerry Lozner, is another possible solution to this problem.

The two extensive articles by Lozner and Greer about their work at Presbyterian University of Pennsylvania Medical Center (PUPMC) are models of the changes which can be planned for a hospital in order to make it more responsive to its community. These articles present, in detail and occasional duplication, the results of an imaginative cooperative effort of students, community workers, and hospital staff to improve the relationship of PUPMC with its neighborhood. These papers should be read very closely.

The problems discussed in these articles are not new. These articles are significant, however, since they report real experiences and real attempts to meet problems and they are not editorials. They should be read for insight into the complexity of the problems and for the potential of the solutions.

Community Pharmacies in North-Central Philadelphia

Steve Marder

The encounter between a black ghetto resident and a white professional takes place in a number of different institutions. This summer I studied the encounter at its primary source in the community—namely, the community pharmacy. The purpose of the study was to evaluate how well existing pharmacies were meeting the expressed needs of the poor people whom they serve. To do this, the opinions of the black community were evaluated and integrated into a questionnaire for pharmacists. In this manner, the health professional would, by necessity, be responding to the opinions of the community.

For the purposes of this study, the areawide Citizen's Council of Philadelphia's Model Cities Program was used as a source of community opinion. Conversations with the Human Resources Standing Committee indicated that information which I could compile would be useful in the action programs they are presently planning. The Health Department based Model Cities Staff provided the expertise and influence that would guarantee that I could find maximal involvement in the medical-pharmacy establishment.

Especially useful in evaluating community opinion was a report by the Human Resources Standing Committee entitled, "Barriers to Good Health," and meetings with the Committee. The report indicated that the community viewed deficiencies in pharmacist services as being closely allied to deficiencies in the services of other health professionals. The report asserts that there is, "a lack of quantity and quality of doctors, dentists, druggists, visiting nurses, and other health specialists." The community indicated that pharmacies are often not open when the people need them and that they are often inconveniently located. It was also recommended that a system should be developed which would provide necessary health services, including drugs at prices that people in the community could afford.

When interviewed, the pharmacists disclosed an image of a profession which was more or less falling apart. Of a total of 102 pharmacies located in the Model Cities Target Area in 1960, only 57 remain open for business today. Indications are that this decline will continue. At least 10 of the 43 pharmacists interviewed already had definite plans for closing. This marked decrease is not unique to the black ghetto. There is an overall tendency in Philadelphia for the total number of pharmacies to decrease at a rate which is not too different from that in the Model Cities Target Area. The difference lies in the fact that in most areas of the city, small "one-man" pharmacies have been replaced by larger, more modern stores. This has not been the case in North-Central Philadelphia.

The survey indicated that the problem lies as much with the pharmacist, himself, as it does with the economics of the area. The pharmacist in the Model Cities Target Area is rarely a young man. He is almost always older than his middle fifties and is often in his sixties and seventies. He has usually owned his store for more than 30 years and he continues to run his store with himself as the only pharmacist. The North-Central Philadelphia pharmacist has probably not remodeled his store in any manner in the past few years. Instead, he has allowed it to deteriorate until today it is often small, depressing, and dirty with a rather scanty inventory available on the shelves.

The most important factor preventing the North-Central Philadelphia pharmacist from providing the kinds of services the community wants lies in the attitudes he has towards his business. He very rarely has any ambition to improve and expand his pharmacy. Rather, he is quite content to manage whatever profit he can from his business until he retires. In order to detect what flexibility there might be in the system, I spoke to several of the pharmacy leaders in Philadelphia, including representatives of pharmacists and the pharmacy schools. From these men I obtained several ideas of how pharmacists in the area might alter their businesses to better serve the community and increase their profits. The idea included stores merging to form larger, more modern pharmacies and prepaid drug programs which are improved over today's Public Assistance plans. It is interesting that when questioned, pharmacists showed little enthusiasm for any of these proposals.

All of these results were taken to indicate that if we use the consumer's needs as our basis for evaluating the services being rendered by pharmacists, the present personnel are likely to continue to fail. The character of the business and the age of the pharmacists would seem to serve as a good basis for inflexibility. The problem in this case lies not so much with the fact that pharmacists are unable to solve their problem, but more with the fact that most did not have any great hope or ambition for their businesses.

Probably the most important conclusion which comes from the survey is that new sources of pharmacists must be found to serve North-Central Philadelphia. The obvious solution which comes to mind is increasing dramatically the number of black pharmacy students. There is also a necessity that the gaps left by pharmacies which are closing should be filled. Discussions with the community have already brought up several possibilities which are being investigated. These include cooperative drug stores replacing pharmacies which have closed, pharmacies in District Health Centers, and Neighborhood Health Centers, and programs to keep hospital pharmacies open during the evening.

Philosophical Conflicts of the Temple Community Mental Health Center's Day Program

Bess Aronian

The day program of the Temple Community Mental Health Center is an experiment in community psychiatry. The philosophy of the program was defined largely by its director, Dr. Frederick B. Glazier, who used Day Top Village of New York as his model. Because of the highly innovative nature of the program, Dr. Glazier has had many problems to face since its inception last September. I will first discuss one of these problems and then briefly explain the philosophy of the day program.

One of the major problems faced by the program is its validation as therapy technique and thus its potential as a model for the establishment of future day programs. This involves bringing about its acceptance by the mainstream of psychiatry. At the present time, the Temple University's Department of Psychiatry has not considered the day program especially suitable training ground for its medical students and residents. It helps to understand this when we realize that the frame of reference of the day program and that of traditional psychiatry are so different that comparison becomes very difficult. Psychoanalysis and other Freudian based therapy techniques face many barriers when considered as treatment methods in community psychiatry, especially when the community is the black ghetto. First, there is the problem of sheer numbers. Temple Community Mental Health Center is the only psychiatric facility servicing an area of North Philadelphia with a population of approximately 215,000. The verbal facility normally required for successful psychiatric treatment would be a barrier with this population, as would the medical terminology usually employed. Also, the crisis orientation of this population makes it unlike the middle class from which psychiatry has traditionally drawn its clientele. As a rule, people in the ghetto are approaching or are at the breaking point before they seek help—many do not voluntarily seek help, but are brought to the center by the police or their families. Generally, middle class people seek help before a crisis is incipient. It is significant that the stress psychoses produced by ghetto living have been likened to those observed in combat veterans.

These are some of the problems which Dr. Glazier has had to consider while evolving his program into a working treatment center. He incorporated many ideas into his program, probably the most significant of which is his conception of the behaviorally oriented therapeutic community. The device used to implement the formation of this community is that of multiple, interlocking group therapy. There is virtually no one-to-one therapy between the patients, or members as they are called, and the staff. Basically, the therapeutic community depends upon the responsible behavior of each member towards himself and every other member. Responsible, mature behavior is encouraged by the staff and "sick" behavior is discouraged. The community is a democracy in which the traditional authoritarian role of the staff members is relinquished. Dr. Glazier is known as Fred, and his opinion, which counts equally with each of the members as one vote, can be overruled. The members, themselves, are the therapeutic agents for each other, and the openness of the community accounts for the fact that a person like myself, who is neither member nor staff, can function with the group.

Although the National Institute of Mental Health evaluation report recently issued states in reference to this program, "It is our opinion that this day program constitutes the model of what a therapeutic type of day program should be," Temple's Department of Psychiatry remains doubtful, and maintains at best a tenuous relationship with the Day Program.

The Saga of Fidel Cruz

Tom Fiss

The following is an attempt to illustrate the problems of the clinic system as encountered in a midcity hospital in this area. The system is a mire, bogging down, and hindering those who administer it, those whom it claims to serve, and those who attempt to reform it. The administrator too often becomes frustrated and overwhelmed by the system. The patient becomes a unit of the system frequently processed but seldom treated. The reformer becomes quickly disillusioned. He's told that change must be slow but too often slow movement becomes complete halt.

Tuesday morning, July 16, Fidel Cruz, 72, walked into the community center complaining of dizziness and marked auditory dysfunction. It was discovered that the patient could not hear with his right ear because it was impacted with wax. The Rene-Weber test showed that the ossicles were functional. The physician-in-charge called the ear, nose, and throat clinic (ENT) at the hospital for an appointment so that Mr. Cruz should be there at 11 a.m. When Mr. Cruz was told of his appointment, he protested vehemently. He wanted no part of the hospital—he'd been there before too many times. They had X-rayed him, palpated him, hooked him up to wires but nothing had ever been done for him. But Mr. Cruz was persuaded that things would go better this time. Mr. Cruz walked the three fourths of a mile to the hospital, was on time for the supposed appointment, but was told the doctor would not be present until 1 p.m. Mr. Cruz went home and returned, by foot, at 1 p.m. At 3:30 p.m. Mr. Cruz was told that the doctor would not be in that day.

Wednesday, July 17: In the case followup, staff member, Santo Smith, encountered a rather aggravated Fidel Cruz. He vowed never to return to the clinic.

Thursday, July 18: To prevent a repeat of Tuesday's fiasco the day's activity was planned carefully and precisely. The ENT clinic was called and it was discovered: 1. that although the doctor does not arrive at the clinic until

1 p.m. the patients are told to report at 11 a.m. so that they would be on hand at the doctor's arrival; 2. the doctor would be present today. Santo Smith would act as patient advocate and translator (Mr. Cruz spoke only Spanish) to insure a successful outcome. With some difficulty Santo convinced Mr. Cruz that it was best for his health if he went to the clinic today. Santo guaranteed Mr. Cruz that the outcome would be different this time. Santo and Fidel arrived at the clinic at 1 p.m.—"ahead of the doctor." At 2:30 p.m. Mr. Cruz wanted to leave because the doctor is not coming." Santo inquired and was told that the doctor would be delayed until 3:30 p.m. Santo calmly informed Mr. Cruz that the wait would be worth his while. At 4:30 they were informed that: 1. the doctor was detained in surgery and would not be in that day; 2. clinic hours were over for the week. Santo reported that Mr. Cruz was extremely agitated.

Friday, July 19: Needless to say, by this time Fidel Cruz had become a legend in his own time. Interest was taken in his case by the physician at the community center who called the hospital for Fidel's file. In the past few months Mr. Cruz had had an X-ray, EKG, PPD, and various other tests to satisfy an intern's academic curiosity. There was only one remark concerning Fidel's hearing "right eardrum not visible."

Monday, July 22: The hospital ENT Clinic was called. The clinic may have hours Thursday.

Wednesday, July 24: ENT Clinic still uncertain about hours. Call 12:00 tomorrow.

Thursday, July 25: The doctor will be in at 12:30 p.m. but will leave at 1 p.m. if not enough people are present. Mr. Cruz was not able to be contacted. No clinic hours until next week.

Tuesday, July 30: Mr. Cruz visited the center today. He felt much better. He still had no hearing in his right ear but his morale was good. Mr. Cruz had not unreasonable doubt concerning the value of his clinic visits and expressed a desire that they be terminated. The physician in charge complied with his very reasonable wishes and dismissed him.

Presbyterian-University of Pennsylvania Medical Center (I)

Frank Greer

"Proposed projects include a Child Health Project and developing roles for community aids to reach people not now covered. Home visits, group sessions at the hospital and placement in the Family Planning Clinic, birth control education, or in the receiving ward."

It was about 10 weeks ago that I read the above words in a massive publication by SHO describing the various summer work sites in Philadelphia. I suppose the words "Child Health Project" attracted my attention, and I made the work site at Presbyterian-University of Pennsylvania Medical Center (PUPMC) my first choice as a work site.

Arriving here in Philadelphia, I hesitantly decided to live with a black family in Mantua. Though I went through some traumatic experiences, it was an invaluable part of my summer. When the people of the community learned I worked at PUPMC they immediately wanted to "fill me in" on what they knew about the hospital. I got many reactions from community people about the hospital, most of them negative. For example, consider that case of Mrs. B., who lived across the street from me this summer. On Sunday, June 23, she had stomach pains and went to PUPMC. After a long wait, which she didn't seem to mind, she saw the doctor in the receiving ward (RW). He gave her some pills and told her to call the hospital on Monday for an appointment for Tuesday's Medical Follow-Up Clinic. So, at 9 a.m. on Monday, she called and was told by the admission clerk that clinic was in session and to "Please call back at 1 p.m." At 1 p.m. she called back and was told "The book (appointment book) hadn't come back yet—please call back at 3 p.m." Calling back at 3 p.m. she was told that she couldn't get a clinic appointment before July 9. She tried to explain that the doctor had told her to come on June 29. Ultimately, she received a clinic appointment for July 9. Mrs. B. was the victim of a great deal of run-around. As she did not have a telephone, this cost her 30 cents. When asked why she had gone to PUPMC in the first place, she gave as a reason the fact that her brother had been treated "just swell there." In general, however, despite her treatment, she described things at PUPMC as "pretty nice."

As another example, take the case of a neighbor, Mrs. S. She related how a nephew had been treated at PUPMC two years ago. Having received third degree burns, he reported to PUPMC on Monday, only to be told to come back on Wednesday. Instead, he went to the Veterans Hospital that very same day and was admitted immediately. Mrs. S. expressed disgust with PUPMC, not being able to understand why her nephew had not been admitted.

Mrs. W., also from the community and who was employed by PAAC, expressed the belief that PUPMC was just too "high and mighty." She recalled the time when no black patients were accepted at PUPMC and a specific case where a black nurse had sued the hospital for the right to work there. A friend of hers had told her that the Bookkeeping Department was "bad" at PUPMC. The friend had been billed repeatedly for a service for which she had paid before leaving the hospital. Surprisingly enough, Mrs. W. thought that the hospital turned away Department of Public Assistance patients.

Taking another case, Mrs. E. said that she and her family used the hospital regularly. Her son was employed there. But she did mention the fact that she had a great deal of difficulty in making clinic appointments. When she telephoned, the extension was always busy and she was asked to "hold" or to "call back later." Having no phone, she found it less expensive to spend 50 cents carfare and to make the appointment in person at the hospital.

Finally, take the case of an old white woman living in Mantua. She reported that "Presbyterian was a good hospital, but I wouldn't touch it with a 10-foot pole."

After having heard such comments about the hospital, I and my colleagues felt that there was a serious schism between the hospital and community. We attributed this to three basic factors:

1. Patients were generally dissatisfied with long waits in the Receiving Ward and felt that there was discriminating behavior on the part of the RW personnel.

2. Many of the community people could remember, or were told, about the former segregationist policy of the hospital. They felt unwelcome at PUPMC as people from a black, economically deprived community. Indeed, one woman boasted about the fact that her teenage son was the first black baby born at Presbyterian.

3. Community people were afraid of the "research" going on in the hospital, particularly after its affiliation with the University of Pennsylvania. Many older people expressed the fear of being used as guinea pigs. If one died at PUPMC, then his kidneys, eyes, etc. were removed for transplants, and even the corpse was given to the medical school.

Thus, as a result of our first two weeks experience, both in and out of the hospital, our point of focus became directed at hospital-community relations. This problem can be attacked on two different levels as is exemplified by programs at several area hospitals. On the one hand, one can work towards the improvement of community relations with the idea of improving health services to community people already making use of the hospital's facilities. Such programs are being conducted at Temple and Jefferson Hospitals. On the other hand, one can work towards improving the hospital's image with the community at large. This approach could not include the specific in-hospital tasks required of the first level. Rather, it would involve close contact between hospital and community so as to keep the hospital informed of the community health needs. The hospital would also be kept in close touch with other community institutions and cooperate with them when asked to do so. This would probably involve the hospital in community activities not often considered a part of "health" except under the broadest definition of the word. Such a program is currently underway at Misericordia Hospital.

Our approach to the problem of hospital-community relations has been on both levels this summer, though our daily emphasis has been on the first level, the theory being that by improving hospital services, patients will act as catalysts to improve relations with the community at large.

Invited into the hospital initially by Dr. F., we began first to investigate his Pediatrics and

Well-Baby Clinics. He had expressed concern that his Pediatrics Clinic had not been growing appreciably in the past years and that a very high percentage of clinic appointments were broken. We noted one fault immediately in the appointment system for the Pediatric Clinic—patients were admitted only after they had first been seen in Receiving Ward. Thus, a mother with a sick child could not simply call up and make an appointment for the child, being required first to bring her child into RW, which automatically meant a long and inconvenient wait. Now appointments for the Pediatrics Clinic can be made directly by telephone. Turning to the problem of broken appointments, I began to call on all of the patients signed up for Pediatrics Clinic, on a given day, on the morning of the afternoon appointment. About one-third of those patients whom I was able to contact, admitted they had indeed forgotten the afternoon appointment. Of those who said they would not keep the appointment, about two-thirds stated that the child had improved significantly and that it was felt that the appointment was no longer necessary. The other one-third said that circumstances had arisen making it impossible to keep the afternoon appointment. It is interesting to note that I met with very little hostility on these calls in the black community. Many people expressed surprise that PUPMC should be so concerned about them.

In another project in the Pediatrics Clinic, we found that many patients unable to afford immunizations were being referred to the District 4 Health Center at 44th and Haverford Avenue. At one time, someone from the hospital had picked up free immunizations supplied by the city and brought them to PUPMC for administering. However, it was felt that this was not worth the time of a paid employee so it was discontinued. We felt that this was bad policy on the hospital's part, as many patients referred to the Health Center would never bother to make the extra trip. Of course, it was argued that this was not any fault of the hospital's; but such an attitude showed genuine lack of understanding. People in Mantua are faced with many other priorities which they usually place above that of good health care. The only time they would bother to come to the institution was when they are ill. Thus, it is to be expected that such patients would not make any extra efforts to receive immunizations. The hospital would be doing a favor for themselves as well as the community by supplying these indigent patients with the necessary immunizations. Jerry Lozner and I made the trips for these immunizations this summer and have worked out a plan with the Volunteer Department for their continuance this fall.

Other suggestions for the Pediatrics Clinic included providing some sort of entertainment for the children. As patients are instructed by the clinic admissions desk to register at 12 noon for a 2 o'clock clinic, it is not unfair to ask the hospital to provide the children with some sort of amusement. To make matters worse, many patients feel that if they register before 12 noon, they will be seen earlier. Of course the obvious solution would call for a supply of toys for the Pediatrics Clinic, but then several objections were raised to this proposal. It was pointed out that such toys would quickly become dirty and serve as germ carriers. However, it is also noted that toys can be purchased which can easily be cleaned by the Housekeeping Department, and besides, many of the children's personal habits spread so many germs around the clinic that a few more would not make much difference. Another objection to the proposal was that in many cases the children would raise a fuss if unable to take the toys home with them. This objection can be answered easily. It is all a matter of discreet selection of the toys. These are indeed toys which children would not expect to take home with them, i.e., a set of wooden blocks or a black board mounted on the wall. Or, inexpensive toys could be supplied which could be taken home by all children. Such items can be bought wholesale at half-price, and the necessary funding can be made available through organizations such as the Ladies Aid Society, etc.

After the Pediatrics Clinic, we turned to an examination of the Emergency Room. The Emergency Room at PUPMC, like many others across the country, is becoming a sort of community doctor on call 24 hours a day. Thus, in addition to non-ambulatory emergency patients, many patients come in with dog bites, colds, earaches, indigestion, etc., and they manage to keep the waiting area filled at all times. It is nothing for a patient with a dog bite to sit from 9 p.m. to 3 a.m. waiting for a tetanus shot. To be sure, the long wait could not be blamed on the nurses and interns who are always working to capacity. What is dearly needed is additional employees for the Emergency Room, not to say anything about additional facilities. It is hopeed that paramedical personnel can be hired to screen out those patients who can be treated without the aid of a doctor.

It was unfortunate to observe that several interns assigned to the Emergency Room were apathetic towards the patients. They would often verbally compare the patients to a herd of cattle and administer inappropriate care. They openly expressed disgust with patients they saw repeatedly. This exemplifies a problem not only for the hospital but of medical education in general which turns out such products. In one case in particular, an intern refused to become legally involved in what was clearly a case of child abuse. Fortunately, this attitude was not characteristic of all the interns.

There are several obvious faults in the operation of the Emergency Room which can easily be corrected. For instance, at night the Emergency Room handles compensation patients. They are given first consideration and their names are placed ahead of all other waiting persons. The unfortunate part is that most of these compensation patients are white. Thus, to the black patients, it appears that white patients receive preferential treatment, as they do not have to wait. This situation does nothing toward improving the hospital's image in the eyes of the community.

Another hang up in the Emergency Room is the "temporary" appointment cards which are dispensed to patients referred to a daytime clinic. Patients see the date filled in on the card (if they are able to read) and think they already have an appointment. You can imagine their chagrin when they show up for clinic only to find that it is closed or that the date written in on the card is an incorrect one. The appointment must be confirmed by a telephone call, and as we have already noted, this simply adds to the critical telephone line shortage in the morning hours at the clinic.

Turning to the out-patient waiting area in general, we have noted the need for a number of changes and have been able to effect them in some cases.

First, during the summer heat spells, the out-patient areas are unbearable. Temperatures near the 100 degree mark have been recorded this summer. The entire waiting area is served by two small fans. Air conditioners should be installed; (the nurses who have air-conditioned cubby hole, responded to this suggestion sharply: "Well, what did people do before you had electricity?") It is realized that the circuits in the out-patient areas are being utilized to capacity, but something should be done about the situation. It is certainly not a very healthy condition as it exists now.

Secondly, lighting is extremely poor in the out-patient areas. One would think the hospital was trying to drum up business for the Eye Clinic. If the overloaded circuits negate the addition of more lights, then either the ceiling or the lights could be lowered.

Thirdly, unlike the waiting room in the ground level of the Private Wing, out-patient areas are not supplied with magazines. We instituted the placement of magazines in these areas this summer and hope the project will be continued by the Volunteer Department. Still needed, however, is a selection of magazines which circulate almost exclusively among black people—*Jet*, *Ebony*, etc.

Fourth, at the beginning of the summer, the restrooms in the out-patient area were very unsatisfactory. At times they were so filthy and smelled so badly, that it was an insult to use them. After dropping a few hints in the right places, we are happy to note that conditions have improved considerably in the past month.

Fifth, a program, which has been instituted at Jefferson Medical Center and is planned at Temple, is a milk and juice service in clinic areas during peak hours. At Jefferson no charge is made to the patients, but it could be instituted for a small fee if necessary. Proceeds from the sale could be used for a scholarship fund, etc. Many patients arrive in the hospital without breakfast, not realizing the long wait ahead of them.

Sixth, one aspect of the clinic admissions desk which bothered us was the fact that patients were called by numbers and letters rather than by their names. This was certainly a very dehumanizing experience on the part of the patient. Recently, we have cooperated with the clinic admissions desk in instituting a system of registration whereby the patient's name is used, not his number or letter. We hope that this procedure will be continued in the fall.

We have also done some work on the second level of hospital-community relations—improving the hospital's image with the community at large. We first considered the possibility of putting more community people into the hospital, either on a salaried or a volunteer basis. Looking first at the employment situation, we found room for improvement. For instance, there were 80 vacant positions for nurses in the hospital in July. Forty of these were for R.N.'s. Twenty were for senior nurses' aides and 20 were for junior nurses' aides. To qualify as a senior nurses' aide at PUPMC, the candidate must have two years of previous experience as a senior nurses' aide, yet there is no program here where the necessary 2 years' experience can be gained. Also, the hiring practices of the hospital are very much open to criticism. Applicants for employment are often rejected because they wear "large, dangling earrings" or "too much eye shadow." We were never able to procure the necessary information to determine the percentage of employees from the immediate community, as there was no way of finding out that information, so we were told.

We also were interested in recruiting more black volunteers at PUPMC. During the summer months, PUPMC, a hospital in the midst of a black community, had no black volunteers. During the remaining months of the year, PUPMC has only one black volunteer. The Volunteer Director admitted that no attempt has been made to organize an active recruitment program. As a matter of fact, the neighborhood Presbyterian Churches have not even been approached. It is thought by the director that the most reliable volunteers from the black community are just not dependable. Though this may be the case in some instances, and it may be true that most black people from the community cannot afford to volunteer, the fact remains that at Temple University Hospital, black candystripers from the immediate community compete for the positions which require one to be on the job five days a week from 10 to 3. If it can be done at Temple, it can be done at PUPMC. All that is needed is a little initiative.

Consider the case of Robert P., a black 14-year-old who lives about two blocks from PUPMC. Robert was one of two students recommended by Salzberger Junior High School for volunteer work at PUPMC. Having spent some time here last year as a patient, he was excited about working in the hospital. As a matter of fact, I talked with several of his friends who said that all he ever talked about was hospitals and doctors. Robert reported to the Director of Volunteers and was told that he might be placed in one of the laboratories. A few days later, he received a letter from PGH saying that he had been recommended to them by the Volunteer Director at PUPMC. He worked at PGH this summer, and the laboratory jobs at PUPMC were given to white boys (probably sons of doctors) of about the same age. As many positions as PUPMC has open for volunteers, Robert P., a student from the community, was recommended to PGH. In mid-July, Robert, who still wanted to work at this hospital, applied for employment, only to be rejected on account of his age. That same week, another 14-year-old was hired by the Dietary Department as part of some sort of Youth Corps Program. But, this same hospital, several days before, had no place for a boy of the same age and of a very enthusiastic nature.

Still another aspect of hospital-community relations on this level is the cooperation between hospital and other community institutions. We have successfully opened up a channel betwen PUPMC and Drew School located about two blocks east of the hospital, through discussions with the principal. As the same families make use of both institutions, there is certainly value in mutual cooperation. In the fall, both institutions are beginning community advisory committees on which a representative from each institution will sit. An agreement is in the works between Hematology and Drew School. Hematology plans to test the school children for anemia in return gaining data for its research on sickle-cell anemia. It is presumed that PUPMC could cooperate similarly with the community institutions—schools, churches, YGS Health Clinic, etc.

Another way the hospital could serve the community-at-large is in the area of family planning or sex education. A representative from Mantua City Planners met with us and discussed the great need for service of this type in Mantua. The SHO group at PUPMC this summer has attempted to get an unwed mothers' group going. It is felt that these young girls who face so many problems would find it of value to share their experiences with one another. We have also met with a clinical teaching nurse at PUPMC. Out of this meeting came a number of suggestions and ideas, including a possible sex education program to be set up by Drew School to be taught by student nurses at PUPMC.

The white man can only play a secondary role in improving the lot of the people in the black ghettos. It is these people who must become cohesive and work together to enact the necessary changes. Fortunately, the community of Mantua is showing signs of this new cohesiveness, especially through such organizations as Mantua Community Planners. It is easy to put a few magazines in outpatient areas or to roll a juice cart through the clinic areas, but these changes by themselves will accomplish little in the field of hospital-community relations. Unless the people of Mantua have a voice in enacting changes in PUPMC's policies, such changes will not be appreciated. Without this community voice, the hospital can make no positive moves in the direction of improving the rapport between the hospital and community. I believe that the time has come when the consumer should have a voice in defining the policy of the hospital which provides community health care. One method of instituting this new community voice would be by filling the position of "patient advocate" with a Black American from the community. Hopefully, this person will be able to set up a committee of community leaders which will function together with a parallel committee of hospital personnel in making new policy as well as redefining existing policy.

To be sure, there is the imminent danger that this individual will be absorbed and become an additional organ of the establishment. Indeed, the "patient advocate" will come under a great deal of pressure from members of the establishment who will feel threatened by this new approach of the hospital. To prevent this, it will probably be necessary that the "patient advocate" be contracted through a third party, such as diversified university settlements. Though this will certainly be a difficult step for PUPMC to take, I believe that it is necessary to assure that what happened to hospitals in Newark and Rochester does not occur here.

Presbyterian-University of Pennsylvania Medical Center (II)

Jerry Lozner

As a medical student, I have become increasingly aware of many of the shortcomings in the health care delivery system. I joined the Student Health Organization and became involved in the Philadelphia Summer Project, because many of SHO's goals, as I interpreted them for myself, have been extremely meaningful for me. The ideas behind SHO and the Summer Project were many:

1. To orient the health science student to the patient as a social being; to look beyond the patient to his environment; the nature of poverty and its effect on the patient is often neglected. The products of such an education are physicians and nurses who are skilled in the techniques of their professions, but who are woefully ignorant of the sociological factors which affect the lives of their patients.

2. To develop a new model of health science education, with a high degree of student administrative leadership and new ties with community groups, which could be applied to medical training programs throughout the country.

3. To demonstrate an active interest in community medicine, and change in health science education; to recognize failure of curricula to come to grips with the biosocial issues of the day . . . abortion, population control, poverty, racism, euthanasia, drug addiction, war, etc.

4. To become personally involved with the social issues, so our understanding can be increased and our opinions become informed and vital.

5. To implement a multidisciplinary approach to health care.

6. To help develop a new breed of health professional who is prepared to adopt new priorities in his professional life and encourage his fellows to do likewise. This cannot help but lead ultimately to improved patterns of health care.

A medical student from last year's Chicago Summer Project commented, "Today's medicine man tries to put people and their diseases in context; to see alcoholism in terms of the despair of the ghetto; to see rat bite in terms of the social injustice and greed which create slum housing; to see a difficult or hostile patient in terms of the alienation which society fosters. The new breed doctor is a man who considers that receiving medical help is a right and who considers that the only aspect of medicine that is a privilege is practicing medicine." With these long-range goals in mind, I set down for myself some realistic short-term goals for the summer and for a project which involved not only health science students, but community workers and high school students as well:

1. To plant the seeds for students to start thinking how to best achieve their long-range goals.
2. To implement in any way community rapport with institutions or community rapport with health science personnel.
3. To arrive at, together with the people of the community, concrete needs for better services and to help institute these needs as practices in specifically improving the health care delivery and grievance system.
4. To encourage poverty area high school students to continue their education into the professions.

These then were some of my aspirations as I began working at Presbyterian Hospital some 10 weeks ago. Our working group consisted of two medical students, Frank Greer and myself, and two community workers, both of whom live within the so-called community of the hospital. We were fortunate enough to have two very interested preceptors, to assist and guide us in our efforts.

The preceptors informed us that the Medical Center was especially concerned about the significance of its health services for the community at large. The hospital's decision to remain in West Philadelphia when it became affiliated with the University of Pennsylvania several years ago really implied some kind of commitment to this particular community, "comprised principally of economically deprived Afro-Americans and downwardly-mobile White-Americans." As objective outsiders looking in, we were to be concerned with the rapport between community and hospital. Why was such a rapport almost nonexistent? Why were several of the clinics being used only to a limited extent, especially the Pediatric Clinic? And from the outset, we agreed that we would go beyond just becoming aware of what the problems were, to also set the seeds for some concrete solutions. It was hoped that we, "the student fellows, and the community workers would be personally congruent enough to hear what persons in the community were saying, and would be personally congruent enough to hear what we were saying to each other." This precaution and commitment to the institution and to the community we would be leaving in 10 weeks would help make the summer a more valid and worthwhile experience for all involved.

The first realization I came to was that white people can no longer impose their values on black people. The black people have a very strong culture and tradition of their own of which they can be proud, along with a growing need to help themselves. With this realization, I recalled the words of a black caucus of medical students from earlier this year, "If white students on summer projects do not have this kind of understanding, the projects again turn into yet another summer of white paternalism, another summer where mindless, selfness service finds its reward in covert palliation, another summer in the sun learning how the niggers live."

Hospital personnel were informed of our presence through a letter asking for their suggestions and criticisms. Community people learned of our presence by word of mouth and through attendance at several community meetings. We were beginning to make initial contacts.

My first insight into the hospital was through its welcome pamphlet which is given to all inpatients. On the first page, the following is stated, "Founded in 1871 to 'care for the sick and disabled, with no patient excluded from its benefits by reason of creed, country or color,' The Center has built its reputation on medical and surgical aid, nursing care and the 'spiritual consolation' provided its patient." This statement, of course, was highly inconsistent with the feedback we were getting from community people about the hospital. It was felt that the Medical Center, since it once catered to a certain class of white people, had remained high and mighty. Only now that this class of people was gone, were community people welcome. It was felt that the hospital was using the community. The research and experimentation going on here at the hospital instilled fear in many of the community people. They feared organ transplants or losing blood for sickle cell anemia studies. Many people didn't know that DPA was recognized by the hospital. One person believed that the first black baby born in the hospital was delivered only 5 years ago. Others said that they would rather go to Philadelphia General Hospital for their own reasons. The basic problems seemed to be a poor rapport, poor communications, and a poor understanding on both ends.

Still other people we talked to discussed the confusion in the out-patient areas and the long waits. Others didn't understand the Glover Clinic and its heart surgery. We found that many of the people who came to clinic were really not the ones who needed medical care most. Preventive medicine was something that many people either were ignorant of or considered unimportant. The major concerns were the day-to-day affairs, and a laceration or gushing blood would be one of those.

We spent our first 2 weeks at the hospital finding out more about each other and meeting many people in the hospital, both in Administration and on the medical staff. We were becoming increasingly aware and sensitive to the problems, and we started discussing what we could do about them.

We worked out of the Social Service Department, and we received a lot of help from the staff of that department. We attended Pediatrics and Well Baby Clinics and spoke to the mothers as they waited for the physician. As we talked, we observed. We thought at first that it might be a good idea to serve coffee to these mothers as they waited, but we were advised that because of the crowded space, hot coffee would be dangerous as far as the safety of the babies was concerned.

From the Pediatrics Clinic, we expanded our observations to the Pre-Natal, Post-Natal, Family Planning Clinics, and the Receiving Ward. The community workers began to get together a group of unwed mothers for the purpose of having a meaningful interchange in the discussion of common problems and baby care. Frank and I began looking into the appointment system. I began to look into the nature of the appointment card which is rather confusing, especially for patients who receive it after 5 p.m. The card indicates that the patient is referred to one of the specific clinics on a particular day, but few patients remember that they must call in the next day to make their actual appointment. The small print at the bottom of the card reminding them of this can often be overlooked. The card should state at the top in large letters, "THIS IS NOT AN APPOINTMENT; FOR CLINIC APPOINTMENT CALL EV 2-4200, EXT. 308, BETWEEN 9-10 A.M. Provision should be made so that when they do call there is more than one open telephone line to receive their calls. Too often the lines are busy for such a long time that patients give up and forget about their appointments or come in at the printed tentative time only to find that they cannot be taken.

This problem can be solved in several ways. The most obvious solution would be to move the appointment books down to the Receiving Ward at night. It is not necessary to move all of the clinic books.

Among the people we came into contact with were the Director of Public Relations, the Director of the Volunteer Service, the Director of Personnel, Director of Admissions, and many others. All of these people were very willing to help us, although some did not seem aware of what the problems were or that problems even existed.

I took care of getting together a *Hospital-Community Newsletter*. The purpose of this newsletter was to let the community people know what facilities were being offered to them here at the hospital, what job and volunteer opportunities were available, and most important, how to go about making an appointment. There was no pamphlet of any kind available to the out-patient to tell him how to use the clinics. Pertinent telephone numbers, suggestions, and complaints could be directed to the Social Service Department. Perhaps then, by working together, we could attempt "to bridge the gap between institution and community."

The followup on the newsletter brought several interesting responses. Major response from the community is yet to come, but many people were no doubt pleased to learn about the hospital's interest. Several nurses from the Receiving Ward commented on one particular statement in the newsletter, "The Medical Center through the Receiving Ward tries to function as the family doctor for the community, 24 hours a day, 7 days a week." The community had been informed of a constant service; the Receiving Ward was staffed only sufficiently to supply an adequate emergency service. Here arose another incongruity in communications which demands evaluation.

Frank and I looked into the areas around the hospital where our out-patients come from. About 3,500 patients used the clinics during the month of April, and we plotted their geographical distribution on a map. It was indeed difficult to define the community of the hospital. Mantua wasn't the hospital's community; in fact, there was a proportionately small number of people coming from the Mantua area. Powelton Village had been torn up by relocation, another sore spot in community discussion of the hospital, and there were many patients coming from miles away.

With the start of the Young Mothers' group and the availability of cafeteria rooms for legitimate community meetings in the evenings, we realized that the hospital's commitment to the community fell within the definition of health in its broadest terms. We contacted a clinical nursing instructor about the possibility of involving the student nurses in a sex education or health education program. This was something that members of the community had expressed a need for.

It wasn't until the first night that I spent in the Receiving Ward that I became impressed with how cruel and brutal life can actually be. After seeing a gunshot wound and several lacerations, I felt my stomach sort of turning over inside. I even asked myself what it was all about. And I could hardly find words to answer the intern who called these people animals and looked at our future as extremely futile. When the 4-year-old male came in with gonorrhea contracted from a 6-year-old female, I knew that progress could and would come through education. I hoped that it wasn't true that the United States could be compared to a poker game in the Old West; when a cowboy was caught cheating he would either be killed by the others at the table, or his winnings would be split up among them. Our racial problem has been compared to that poker game. The blacks have found that the whites have been cheating them, and either we'll have to shoot it out with each other, or be prepared to share what we have. We must be prepared now to dispel the idea of white racist institution. Now that communities are demanding relevance, institutions must stop ducking behind elegance. The hospital must be prepared to listen to the needs of the community. And if sex education is an important need, then steps should be taken to fill that need. I have given the clinical nursing instructor resource material from the large-scale health education program being carried on at Lankenau Hospital. Miss H. has contacted a family planning registered nurse who would be glad to take the program under her auspices, although she would have little time for actually running it. Mrs. S. has indicated that Drew School would be an excellent source of young people. So, this then is one program, the components of which can easily be put together.

We also were concerned with the fact that few people from the community were actually employed by the hospital at levels above kitchen and maintenance staff. We did realize that many people from the community could not present the necessary qualifications. Yet, the hospital could use 20 more senior nurses' aides. The problem is that to be a nurses' aide one must have 2 years' experience as a nurses' aide. An aides training program possibly run by the nursing school would be a valuable asset to hospital and community.

Our main focus, then became closing the gap between institution and community and what might be done to improve the rapport. we began seriously investigating the area of patient relations. We found that several programs in patient relations and community relations were already in existence at other hospitals in Philadelphia.

The assistant director of ambulatory services at one near-by hospital, was one of the people we got in touch with. There he has established both a patient relation coordinator and a community relations coordinator. Their main intent is to make the patient's stay more comfortable. Small overtures—juice and milk for patients who have to wait, magazines, clean toilet facilities, furniture and toys for the pediatrics playroom, etc.—receive quite a favorable response. In poverty areas particularly, favorable, as well as unfavorable, impressions move quickly by word of mouth. He has been aiming to add the humanistic touch to the services rendered in the out-patient area.

The Community Relations Director at another hospital, which is white, Catholic, has quite a difficult task for himself. As the only black person on an administrative level at this hospital, he faces the impossible or rather, extremely difficult job of helping a white Catholic institution relate to a predominantly black Protestant community. He hopes to have services rendered by the hospital which not only keep the community healthy, but happy as well. He has organized a dance for the teenagers, study areas for the students in the community, and an enrichment program for the youngsters.

At still another hospital the director of patient relations has done an admirable job. In response to a noise, dirt, and confusion letter drawn up by several physicians in the hospital, she organized a committee to look into some of the inadequacies of the hospital as far as patient relations, and to try to respond to the patients' needs. The head of each staff in the hospital is always ready to address himself to a problem as it comes up. The hospital quickly recognized the usefulness of her work, and her department has now expanded to four people.

Here at PUPMC, we have presented a proposal for the position of patient advocate. This is a community person who could function in the field of patient relations and actually be a human link between the hospital and the community. This step of course would only be like placing a foot in the door toward a solution to the problems we are confronting. Two committees would have to be formed. One committee would consist of community leaders drawn together by the patient advocate; the other and parallel committee would be composed of administrative and medical staff of the hospital. Together, these two committees could function to work on new policy, as well as improve on existing policy. In other words, for the hospital to be really accepted by the community, the community must be involved in desicion-making.

Another valuable resource person we came in contact with was the Assistant Director of University Settlements. He introduced us to his "Design for Service Delivery that Reinforces Constructive Tension Between a Health Center and Its Consumer and Supports Community Power." He emphasizes the following premises:

"1. Individuals within a residential area need their own effective community organization structure if they are to deal meaningfully with the problems they are experiencing.

"2. A geographic area needs a broad based community association that proceeds in a democratic manner and is controlled by residents.

"3. A citizen organization is representative of a community as long as it remains unchallenged.

"4. Public and private service institutions that are truly accountable to their consumers will choose to support rather than undermine community structures.

"5. Institutions that desire horizontal relationships need to provide independent funds for a community organization service."

He has come into contact with PUPMC's Assistant Administrator and hopefully their conversation will be ongoing.

Proposal For Position of Patient Advocate

Goals:

1. To be a human link between the institution and the immediate community, so that the care of patients will acknowledge their humanity and affirm their dignity as persons; hopefully, this will make the patients' hospital visits as comfortable as possible.

2. To work imaginatively with professional personnel in the continuing evaluation, reshaping and development of health services.

Departmentally, working out of either the Social Service Department or the assistant administrator's office would be the most suitable context.

3. To advise patients, many of whom are confused by hospital procedure, of the steps to be followed in gaining admission to, locating and using the clinic facilities in the Medical Center; to be the patients' advocate with the hospital in reporting grievances about services, and to carry out in depth followups on specific patient problems, as well as specific tasks related to making the patients' stay more comfortable.

4. To continue to inform the hospital of community health needs by facilitating communication between community leadership and this institution. This would involve setting up a committee of community leaders which, functioning together with a parallel committee of hospital personnel, could work on new policy formation, as well as making needed changes in existing policy.

5. To be a liaison between this institution and the other institutions serving the community.

Since the goals outlined above will probably prove too much for one person, we conceive of handling these goals in two phases or through two people. For instance, initial focus might be on the first three items, which primarily affect community people already making use of the hospital's facilities. Items 4 and 5 represent a second phase in the project's development. This phase would not include the specific in-hospital tasks required in the first phase, but would deal with the hospital's relations with the community-at-large. This phase might possibly involve the hospital in activities which fall within the definition of "health" in its broadest terms.

Rationale

PUPMC is becoming increasingly aware of the need for cooperation between institution and community for the efficient delivery of health services. The hospital feels frustrated because a medically unsophisticated community often overlooks, misuses, or does not make the best use of the services available; many community people feel frustrated because the hospital does not seem to be as sensitive to the social dimensions of their medical problems as it might be. In other words, the hospital has resources which it makes available to the community but, because these resources are not limitless, it wishes to make the most economic use of them. At the same time, while the community is not equipped to treat its own illnesses, it does know what its illnesses are and could help the hospital identify needs to help facilitate and economize in the delivery of services. If channels for informing the community about medical services could be opened up and if channels for listening to the needs of the community could be developed, delivery of medical care could be greatly simplified.

PUPMC has been struggling to define its relationship with the community for many years. Now that it finds itself placed in an area comprised principally of Black Americans, the Medical Center which held itself aloof from the community bears the stigma of discrimination against the community. This makes the practice of good medicine difficult. Turning now toward the black community, little has been done to acknowledge or deal with the hostility generated out of a history of unfortunate community relations.

Affiliation with the University of Pennsylvania was a function of the hospital's decision to stay in the community and, at the same time, a kind of commitment to the community—to us it and to be used by it. Our recently acquired "research" image sometimes gets in the way, generating fear in many of the people living in the immediate area. Nor are we as aware of the ego-destruction of the Black American as we might be, which makes it difficult for him to cross the threshold of a predominately white institution.

The position being proposed would begin to open up some channels for conversation with the community. Of course, by providing a person to fill such a position, we by no means feel that this negates the entire hospital staff's responsibility to be always listening for the concerns of patients and to be interpreting the hospital to them. Furthermore, it is our hope that, in his language and presence, the advocate will be performing a teaching function for the hospital personnel and will be affecting their attitudes towards community persons in a positive, healing way.

It is significant that the hospital's decision to stay in the community was made in the absence of any serious conversation with community leaders. It seems clear that hospital-community relations could be improved immeasurably if the hospital were to take the community into its confidence regarding plans already made for renovation and development of facilities. It might also prove useful for the hospital to seek further conversation with community leaders in the ongoing task of decision-making. Granted, there are ways of defending the monolithic stance of a medical center, but these can only be posted with complete disregard for the need to involve community persons in decisions which have to do with the life and future of the community.

Possible Credentials

1. The person should reside in the immediate community and have an in-depth understanding of the community surrounding the hospital.
2. The person will need to be especially sensitive to the feelings of other persons and able to perceive, on many levels, the nuances in human relationship.
3. The person should be a Black American, preferably between 25 and 45 years of age.
4. The person will understand or have the ability to learn hospital procedure.
5. The person will be articulate enough to communicate verbally both with patients and professionals.
6. The person will acknowledge a dual responsibility: to community and to hospital—and will possess the personal resources to work within this tension.

SHO AND HEALTH PROFESSIONALS

Karen Lynch

About 80 of the project workers were students who will someday find themselves in roles similar to those of the health professionals with whom they came in contact during the summer. Through the summer project they have been able to examine the role of health professional differently from their usual vantage point as students and prospective health professionals.

Perhaps this experience of observing health professionals, the health delivery system, and the local communities which receive services will, in the long run, have the greatest impact on these students, more than any formal facts and skills which were picked up during the summer.

The following six articles present observations on health professionals. Articles in other parts of this report present indirect observations on health professionals: comments about the Jefferson Mental Health Program, the Consortium's recreation project, the philosophy of the Temple Day Care Center, Gray's Ferry community, and the "Saga of Fidel Cruz," all relate to this topic. In the articles of this section, students address themselves straight forwardly to health professionals and their fellow students.

Bill Halperin discusses a forgotten group in Philadelphia, the poor whites, a group which previously had been excluded from SHO's concern. How to relate to this group remains problematic for SHO and it is one which all health professionals and reformers will have to face.

Both Jefferson Mental Health workers and Temple Mental Health workers were personally involved in organizational problems. Phil Harber and Anne Sheehan discuss the dual reward system which is common to organizations which deliver services. Responsibility to client and responsibility to the serving organization, in theory, coincide and produce no conflict for the serving professional. In actuality, however, conflicting goals and expectations abound. Another common problem of service professions is the determination of the appropriate mode of service and the development of appropriate attitudes in the practitioner toward the client. This problem is accentuated when practitioner and client are characterized by not only different needs but also different values and social backgrounds. Bart Butta and Robert Lewy make some observations on this conflict area as a result of their work at the community "Trouble Clinic of the West Philadelphia Mental Health Consortium."

The experience reported by Darryl Robbins as a summer staff member of Eagelville points out the importance of personal feelings and relationships to others within and outside of professional roles.

The article by project workers at Mantua Community Planners describes another alternative to professional-community relations. This organization provides technical competence in the design and execution of community plans. This cooperative effort is a model of the potential alignment of community people and skilled professionals. Ken Logan and Phil Graiteer present a vignette of the community and MCP projects.

A difficult problem in any human situation is arriving at an understanding of the effects of one's attitudes and behavior on others. Students' comments here point out the sometimes deleterious consequences of professional attitudes on clients and the organizations which they serve. One wonders about the effect of these experiences on students themselves, as they begin to assume the role of health professionals.

The Unexplored: SHO Working in Poor White Communities

William Halperin

Fishtown has been left out. It is a ghetto bounded by the Delaware River, Norris Avenue, and Front Street. Front Street is the "demilitarized zone" across which no black or Puerto Rican people move into Fishtown. Fishtown is a ghetto of white, lower income Americans. Many are white Anglo-Saxon Protestants; there are Irish, Polish, Slovaks, and others. Some are recent immigrants, others have been in America five, six, and seven generations.

The community is a combination of old brick row houses, factories, and small stores. Residents are working class people. Philadelphia's trucking industry, for example, is centered in this area. In a sense, things are not changing for the community—no new housing, no new public works programs, little mobility either economically or geographically for themselves or their children. In a sense the community is changing—motorcycle gangs are becoming more popular; glue sniffing is more prevalent; vacant homes are set afire. In one corner candy and grocery store which was crowded with more than three customers in it, a Polish immigrant of 20 odd years had been robbed innumerable times.

One cannot consider this a poor community or call it low class. The residents would see this as an insult. They demand other euphemisms—lower income. However, the problems remain the same: a high drop out rate—1 percent go on to college; many dilapidated and vacant homes; unemployment. One block on which I helped a resident try to organize a Tot Lot had only two of 13 families supported by wage earners.

The community is just beginning to perceive that it has problems. It is beginning to understand that the police must be badgered into towing away abandoned cars. The people are realizing that outsiders are not abandoning and stripping all the cars, but that their neighbors are responsible. A late model Pontiac with a flat tire and a smashed fender was turned into a worthless shell 2 days later. I watched a neighborhood youth of 12 or 13 remove the radio. A public parking lot on Moyer Street, a residential street, is abandoned by the city because it is not used. A woman told me that your battery would be stolen by your next door neighbor. She was not angry. She merely accepted such behavior as quite normal.

Normal behavior is broadly defined. For instance, alcoholism is not perceived as a problem. Most believe that all who drink need another shot in the morning to steady themselves to get their shoes on. Black-outs are thought to be normal for those who drink. A sociology graduate student is presently attempting to collect information on the residents' knowledge of alcoholism, mental health, and other welfare problems. But it would be quite reasonable to expect little knowledge about these areas. There are no health agencies in this area.

Fishtown has been left out. Fishtown is just outside the model cities boundary. It was not included by its own choosing. To be simplistic: Fishtown has vacant homes—model cities means rehabilitation and open housing. Open housing means blacks and Puerto Ricans. It is in this community that a true race riot has occurred in recent years. This was precipitated by a black family moving in. More recently two black kids were "cut up" when attempting to go swimming in the Fishtown pool. Black faces are perceived as a major problem. A local resident employed by the state explained this fear as a defense mechanism. Fishtown residents have very little except their patriotism (one of the highest Marine enlistment rates) and their supposed white superiority. Integration of poor blacks who, by most criteria (income, education), are the Fishtown residents' equals would destroy their last defense, that irrational belief of white superiority. Therefore, in fact, Fishtown leaves itself out of many programs which could prove to be beneficial. But there are other reasons it is left out.

The community is "solid" in a negative sense. It acts together to keep blacks out. Community solidarity does not work in positive directions. A very eager, unselfish shift worker was asked how much he was being paid to help better the community. The only community worker, who is also my preceptor, was accused of having real estate interests. But then again the accuser thought that two major evils are the international Communist menace and the teaching of Darwinism in the schools. The community does not seem either worried or astonished that the Delaware Expressway not only has demolished many homes, but will run on a graded mound through the community. The Fishtown Civic Association with its 88 members is trying to face some problems. It is investigating trying to gain a mini-school like the one in Mantua and trying to have the abandoned homes in the expressway's path torn down before they burn. Fishtown is left out because it has never gotten itself "together" for constructive purposes.

The third reason that Fishtown is left out is that the government and other establishments leave it out.

There are several possible explanations. The most obvious is exemplified by SHO's summer project. Letters were sent to agencies, community groups, and leaders throughout the city. Since there is only one social service agency and one embryonic civic association, chances were not good that there would be a response to SHO's offer. The proliferation of community groups and projects in the black community is not paralleled in the white community.

Fishtown does not even attract the most simple-minded do-gooders. Fishtowners are dismissed from our social concern because they are bigoted. Working in poor white communities is just coming into vogue for the social activist.

On another level, some modicum of aid is now directed towards the black community because of pressure from that community in the form of lobbies and insurrection. The children of the white poor can be playing in dangerous housing shells, but there is no urgency for the city to act. When our leaders talk of poverty, they mean black people who have been left out because of white racism.

The government responds to pressure. The War on Poverty once was earnestly concerned with poor whites, urban and rural. Urban blacks have now gained most of the war on poverty's attention. Blacks may appreciate the efforts of white people in getting the civil rights movement moving. Now their problem is to determine the path of their own communities.

Poor white communities continue to exist and grow. People live in despicable conditions. Perhaps in addition to facing our own institutions, we must catalyze the reaction of poor white America by building a new human rights movement there.

The Effect of Inappropriate Reinforcement System on Program Establishment

Anne Sheehan and Philip Harber

A Case Study

Miss Anne Sheehan and Mr. Phillip Harber, students in the Health Sciences, participated in the Philadelphia Student Health Organization's Summer Project of 1968; they were assigned to the Temple Community Mental Health Center to work and learn under the preceptorship of the Chief of the Community Organization Section of the Mental Health Center. Their prime activity for the summer was the establishment of a Child Care Service for the West Nicetown-Tioga Neighborhood Family Health Center. This Neighborhood Health Center is an Office of Economic Opportunity Healthright community medical center serving a population of about 30,000 persons.

Throughout the summer of 1968, its opening date was delayed from early July to the middle of August.

The SHO participants attended a tour of the Neighborhood Health Center which included meeting Miss S., Director of the Social Work Department. At her invitation, they attended a staff meeting at which numerous staff members presented the problem of the desire, and funds, for summer employment of high school students being present, without any ideas of how to utilize these individuals. At the close of the meeting, the SHO participants presented the idea of establishing a service to care for children while a family member is receiving medical attention at the Neighborhood Health Center; this Child Care Service would be staffed by area high school students, who will also participate in a training program to qualify them to act as recreational leaders and to facilitate establishment of good community relations for the Neighborhood Health Center. The idea of working with a group of high school students had been suggested by Miss S. to the PSHO participants on the previous day. Dr. C., Director of the Neighborhood Health Center, stated that the idea represented a sound solution to the problem and he agreed that the Child Care Service would be a useful part of the services to be offered by the Neighborhood Health Center. He authorized the PSHO students to write a proposal for the Child Care Service with the guidance of Miss S. When she was contacted, she agreed to provide the guidance and suggested that the students write a proposal to be presented to her in a week's time. The students then wrote the proposal. Upon its completion, the proposal was presented to her; she carefully read it and made certain revisions. There was some lack of clarity as to the next step to be taken; it was decided that the proposal must be approved by the groups along the lines of authority. Numerous problems evolved; these included inability to find a reasonable location for the Child Care Service, question as to the date that the Neighborhood Health Center would open, resistance to the idea by certain staff members, and many details such as insurance. The relationship between the PSHO students and Miss S. became appreciably strained; finally, Dr. C. and Mr. O, Administrator of the Neighborhood Health Center, were called to a meeting with Miss S. and the PSHO persons. At this meeting, the project was approved by Dr. C. for presentation to the Executive Committee and to the Neighborhood Board of Directors for approval. A final revision of the proposal was prepared in consultation with Miss S. The proposal was approved by both groups; Mr. J., Assistant Director of the Program, was to present the proposal to the Philadelphia Antipoverty Action Council and to the Office of Economic Opportunity for approval. Miss W., acting Director of PAAC delayed approval. Dr. C. presented the proposal for unofficial approval to a visiting OEO official. After a delay of about a week, Miss W. approved the proposal. The implementation of the program then began.

This paper will attempt to analyze one of the causes for the difficulties encountered in gaining approval of the program. The implementation of the program will not be described; nor will other causes of difficulties be considered. No attempt is being made in writing this paper to provide a comprehensive view of the SHO participants' activities during the summer of their placement at the Temple Community Mental Health Center. Since the cause of the problem lies primarily in the medical "establishment" ostensibly engaged in delivering medical and social services to the poor of North Philadelphia, the paper will focus on "establishment," rather than "community."

Since the "private entrepreneurship" form of medical service does not function in North Philadelphia, service is provided (when it is provided) by relatively large institutions. This results in a separation of the recipient of a service from the purveyor of the service; this separation may be temporal (it was difficult to produce enthusiasm for the proposal since enthusiasm or action at the early stages would bring no immediate benefit); physical (most of the "high" administrators do not live in the area they serve; their offices' walls and air conditioners separate them from the people they are mandated to serve); social (many of the "professional" employees cannot identify with the problems of those they serve); bureaucratic (the duties of many prevent them from meeting the people they serve), or of another nature.

This separation produces an inappropriate reward system. Because the employee in an administrative position receives rewards from other administrators, rather than the "community" to be served, he acts to please the administrator, rather than to deliver real service.

There are two determinants of the nature of the reward system: the individual's responsiveness and the structural design for operation. The former of these determinants is largely determined by the latter; to the extent that it is not determined by the latter, it is extremely difficult to manipulate. The latter reason, the structural design, is artificial and, therefore, subject to manipulation.

There are several structural causes of the separation of recipient of a service from the purveyor thereof; the most significant of these is the role definitions for employee positions. Also contributing to the separation is the increase in the proportion of time spent on non-service administrative work as the group delivering service increases in size. Furthermore, racial and social barriers accentuate the barriers between patient and health services personnel.

The inappropriateness of the reward system reduces the quality of care delivered and, perhaps more significantly, reduces the possibility for meaningful change in the methods of health care delivery. While the West Nicetown-Tioga Neighborhood Family Health Center is, itself, an experiment in health care delivery and incorporates several innovative approaches on a broad level, its staff shows a marked reluctance to experiment with, or even think about, changing the way they do their individual jobs. "Job Description" for each employee is quite sacrosanct; employees are bound to their specific tasks as with the most stringent labor contract. Since the Neighborhood Health Center is seeing a minimal number of patients, the staff has no real contact with those to be served; many administrative officers stress plodding along without "causing any trouble." This probably results from the fact that they are in no way responsive to the needs of the community; they are responsive to an Executive Committee, composed largely of administrative medical personnel, and to a "Neighborhood Board of Directors." This last body supposedly represents the community, although it has been said that only three of the 15 positions on the Board to be filled by community residents are actually filled by people residing in the area served by the Center; more importantly, the Board and administration associated with it are highly defensive; their greatest reward is lack of any form of opposition. This naturally leads to fear of change.

An example of the way in which fear of innovation operates to delay service is provided by the Child Care Supervisor. One of the first tasks assigned to her by the Director of the Social Work Department was to write herself a job description. Later, she was able to rely on that document to justify her delays in the establishment of the Child Care Center, stating that her job description precluded her from doing some of the things necessary for easy establishment thereof.

Factionalism is another result of responsiveness to something other than the quality of service provided. When one can receive reinforcement only from within one's "unit" and can increase one's bureaucratic status by increase in the size of one's "unit," it is natural that there is more interest in the "unit" than the community. This was evident in several ways.

The Mental Health Center and the Neighborhood Health Center, do not now cooperate to any significant degree, while it would appear logical and even necessary according to OEO Guidelines* that the two cooperate.

In providing psychiatric services, the Neighborhood Health Center is seeking to establish its own psychiatric service. There is a basic mutual distrust and dislike between the two organizations which became quite evident at a staff meeting of both centers. It has been said that at a meeting of the Neighborhood Health Center's Social Work Department, the director explained her reservations about the establishment of the Child Care Service Program on the grounds of a fear that the Director of the Mental Health Center would attempt to direct one of "her" programs through the SHO participants.

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* Healthright funds are to be used only as a "last dollar" when no other service or support is available; Neighborhood Health Centers are to cooperate with, and utilize, the services of other community service groups whenever possible.

There is also animosity between the Temple University Hospital and the Neighborhood Health Center. This is evident from the reactions of staff to including "Temple University" on their sign.

The necessity to have one's positive service viewed as a service of the "unit" results in the exclusion of many services which would not be visible as a "unit" product. A possible reason for refusal to even consider caring for children while a family member visits an OPD clinic at any other hospital (before the Neighborhood Health Center opens for service itself) may have been the consequent lack of identification of the service as one of the Neighborhood Health Center. While the nature of the funding situation may in part account for this answer, it is interesting to note that "service to the community" was not considered.

Besides factionalism, other problems are caused by the inappropriate reward system. One of these is a great diffusion of responsibility. This occurs because administrators at all levels are not required to justify themselves in terms of the actual benefit they provide. It is, therefore, not necessary to personally make any real contribution. Hence, an avoidance of personal responsibility for any project develops. The responsibility for establishment of the Child Care Service was shared by many, of whom the following is a partial listing: Director of Neighborhood Health Center, Director of Social Work Department, Neighborhood Board of Directors, SHO participants, Executive Committee, Program Development and Evaluation Unit, Patient Care Coordination Committee Administration Unit, Child Care Supervisor, Philadelphia Antipoverty Action Commission, Community Action Council Area B, Office of Economic Opportunity. All of these have been involved in establishing the program. Since at the time of any delay it was impossible to pinpoint the responsible party, it was impossible to speed action.

A natural outcome of the lack of any personal commitment to a project is a great indifference to one's work.

Medical and social services in North Philadelphia are provided by fairly complex bureaucratic structures. If rewards were made relevant to one's real service, the tendency to formalize relationships in a bureaucratic structure might be reduced since the structure would be wholly irrelevant to the individual's gratification. The disadvantages of bureaucracy are well known; this summer, the bureaucratic importance of working along established "lines of authority" became quite obvious. Manufactured delays and resistance came about as a result of attempts to bypass the established lines of authority.

As described earlier, the proposal for the Child Care Service was presented at a staff meeting. The Director of Social Work might have suspected a "conspiracy" between the SHO participants and the Director of the Neighborhood Health Center when the latter approved the idea without first consulting her.

While the above example is concerned with assumed (informal) lines of authority, the following is concerned with official lines. After the proposal was approved by the Neighborhood Health Center, it required approval of PAAC, CAC, and OEO. As mentioned earlier, the proposal was presented to an OEO official before PAAC had ruled on it. It has been suggested by a member of the Social Work Department that Miss W.'s relay resulted from this failure to work through the "proper channels."

In the absence of more appropriate reinforcement, many persons are forced to seek ego satisfaction as a result of their occupational status. This may in part account for the inflexibility concerning job descriptions. Professional distinctions are frequently exploited to increase the professionals' sense of worth.

In conversations with persons at both the Mental Health Center and the Neighborhood Health Center, the SHO participants detected a sense of inferiority attached to mental health assistants and to family health workers. For example, the names of individual family health workers do not appear in the minutes of the staff meetings as do the names of all other individuals who attend. Mental health assistants seem to be considered more as equals by professionals than are the family health workers. It appears that the Neighborhood Health Center personnel are more resistant to destruction of professional superiority than are the staff members of the Mental Health Center.

The problem of establishing responsiveness to the wishes and needs of the community has not been answered with the establishment of the "Neighborhood Board of Directors." It has been said that 80 percent of the positions allotted on this body for community representation are held by outsiders. Furthermore, one may question if the Board members do truly represent the community; one may question if the "poor poor" are really inarticulate in Board affairs. Many persons (social workers particularly) claim to represent the community; that they do often appears doubtful.

The system is such that the persons closest to the community—mental health assistants, family health workers, some nurses, etc.—really have the least voice. When the proposal was first presented, enthusiastic reactions came from some members of this group. However, the fate of the proposed Child Care Service was in no way dependent on their reactions; rather, it depended on the wishes of high administration officials. While their support was heartening, it was really insignificant in comparison with the power afforded by Dr. C.'s interest.

Many of the persons who could be most valuable in instituting beneficial changes in the system are prevented from doing so due to a language problem. To institute change within the "system," it is necessary to speak the "system's language. The "system" speaks a bureaucratic language of its own.

The SHO participants encountered difficulty in talking the language of the Neighborhood Health Center. Such terms as "philosophy," "goal," "objective," "staffing patterns," "procedural steps" have very specific meanings which are, in some cases, different from the generally accepted meaning.

Besides the terms developed by each organization to be used internally only, there is a prejudice against improper grammar and monosyllabic words. In writing an acceptable proposal, it was necessary to use quite formal constructions and language. The need to write in a sophisticated manner leads to the exclusion of many family health workers, mental health assistants, and others who have quite valuable ideas, from the rank of those who can develop a program. These persons are stymied when they cannot communicate on the language level established by the 'high" administration. Only the SHO students' academic high school and college education placed them in a position to do what many of the aforementioned cannot do.

It is unfortunate that those who are closest to the community and consequently most responsive to its needs are those who cannot communicate well in the language the "administration" has chosen. This problem is perhaps related to that of status, since exclusion of one's "underlings" on the grounds of their language may be used as an ego-builder by many.

It is natural for the real interests of the community not to be served when the service system refuses to speak the community's language. In general, one gets the impression that interest in the community's reactions is negative in character: only a fear of community disapproval leads to a solicitation of the community. The phrase "getting a proposal through the Board of Directors" was too frequently used.

Despite these problems, it appears that the Mental Health Center is making valid beneficial contributions to the community and that the Neighborhood Health Center will do so when it finally begins to provide full-scale service.

The organizational plan of the Neighborhood Health Center is a fine step in the direction of responsiveness to service rather than to the "administration" of the "system." It is unfortunate that it is not implemented to allow this actually to occur. Several questions should be answered. Why should administrative positions (e.g. Director of Social Work) carry more reward than service positions (e.g. social worker)? Why should a physician not really listen to what a Family Health Worker has to say? Why must the organization rely on token community representation to justify their intrusion into the community? Why are "appearances" rather than real service the basis for reward? Why is health care in North Philadelphia inadequate?

Professionals' Values and Their Consequence on Serving Clients

Robert Lewy and Bart Butta

The main problem of the West Philadelphia Mental Health Consortium is the preoccupation on the part of the staff with their roles as white professionals who are "ethically" obligated to enforce a middle-class set of values and a middle-class oriented psychological theory on members of the community for whom this is totally inappropriate.

Consider an interchange which transpired on August 12. A student had requested a psychiatric evaluation of an alcoholic by a consortium psychiatrist. The psychiatrist's response was a mixture of apathy, indignation, and a professional-training-bred belief that his profound insights could only be meaningful to a fellow member of the guild. He was not willing to share the fruits of his training with "Mr. Temple Student."

Instances like this are common at the West Philadelphia Community Mental Health Consortium. Even the young people become convinced of the value of discipline and traditional, highly structured, classroom-oriented groupwork methods. Talk of flexibility, responsiveness to the community and innovation from such individuals is almost cynical.

People who enter the Consortium with new ideas are met with feelings of indifference and are subtly undermined, isolated and their ideas are discussed to death. Blacks who lack the "proper" values by nature of class origin seem to acquire them in the course of professional training and profess them with the enthusiasm of a convert. Certain professionals at the Consortium are not totally committed to this approach, but will only confide their doubts privately. The reason for such behavior is *not*, realistically, fear of losing the job; rather, such people are sufficiently guilt-ridden that they are effectively silenced.

A fallacy in this entire approach is that therapeutic effectiveness and even emotional adequacy depends upon professional training. Recent work in the areas of non-verbal communication and cross-cultural therapy (e.g. the work of Jerome Frank) made it clear that what heals is an interaction with an emotionally competent persuasive individual. The professional training prejudice overlooks: 1. The adequacy as parents of nonprofessionals, 2. the inadequacy as parents of many professionals, and 3. our own observations of therapists, former alcoholics, at Eagleville Hospital who have no formal training but are highly effective in their dealings with their patients and people in general. It is unfortunate that such people must become "certified" by obtaining degrees in formal training in order to rise professionally. We submit that such formal training will reduce their effectiveness.

The solution, in our opinion, is not to, as is present procedure, gradually force out "old-line" professionals and traditionalists and replace them piecemeal with "young people." As mentioned above, the new arrivals are simply isolated and swallowed up as their guilt becomes mobilized. What is required is a complete overhaul of the Consortium facilities so that white professionals are immediately and invariably responsible to emotionally competent "nonprofessionals." Such a procedure would release those professionals at the Consortium whose originality and dissatisfaction with present methods have been, by virtue of their responsibility to other professionals, submerged. It is a moot point to what extent such a "release" would occur, but those who are incapable of it should be encouraged to seek the safety of an institution which is traditionally oriented.

Eagleville

Debbie Finkelstein and Darryl Robbins

Although Eagleville is a treatment center for alcoholism, it must be realized that alcoholism is only a symptom of more complex problems in living, part of which is the inability of individuals to communicate. We feel that the Eagleville SHO project must emphasize not only the problems of alcoholism but also stress the importance of being aware of our own feelings. Thus our project expands from alcoholism to the area of human awareness. Therefore, as a part of our project, we have brought several groups to Eagleville. One of these groups was the Soul City and Zulu Nation, two North Philadelphia gangs that "swing together."

Arrangements for the gangs coming to Eagleville for the weekend of July 19-21, 1968, were made through two staff members of the Hartranft Community Corporation. Members of the Hartranft staff sat in on a group therapy session at Eagleville and, being impressed with the group therapy techniques witnessed in that group and in the SHO groups, realized that these techniques would be applicable to working with the gangs. A great deal of gang warring was going on in the community and it was felt that a talking out of hostilities and an honest expression of feelings would be of some benefit. Furthermore, the community workers were concentrating on a $250,000 Federal grant for building and maintaining clubhouses and saw the weekend as a time for the gang members to evaluate their roles as clubhouse members and to suggest clubhouse leaders and administrators.

The gang weekend was successful as far as the gangs themselves were concerned. However, the weekend highlighted the divergent opinions and approaches of the Hartanft staff. A great deal of intra-organization conflict emerged. It was suggested to the Hartranft staff that they put themselves into a group session.

On Friday, July 26, 1968, a member of the Temple Graduate School in Group Dynamics led an all day group session with members of the Eagleville and Hartranft staffs. A list of suggestions for more constructive youth weekends resulted from the day's discussion. However, the Hartranft rift only widened. It was revealed that when the clubhouse money would be received and when the clubhouses would be built had not yet been established. If the money is delayed, and because of the emphasis placed on the clubhouses by the Hartranft staff, not only would the relationship between the community workers and the gang be endangered but the gang's resentment might also extend to the community at large.

When Hartranft left Eagleville that Friday night, the problems within the organization were still unresolved. Although Eagleville is willing to continue working with the Hartranft organization and although gang weekends had been proposed as a continuing program at Eagleville, Eagleville has not been contacted by Hartranft for any futher action.

Eagleville has resources in the forms of staff, residents, and group techniques. The Eagleville staff has shown itself to be adaptable in working with SHO, camp counselors, and Philadelphia gangs. We have found that resident participation is invaluable in a group situation.

Mantua and Mantua Community Planners (I)

Ken Logan and Philip Graitcer

The Mantua community is an underdeveloped residential area located in West Philadelphia. It is a community of about 22,000 people most of whom are of Afro-American descent. The geographical boundaries of Mantua are 31st to 42d Streets on the east and west, and Hamilton Street to Mantua Avenue and the Penn Central Railroad tracks on the north and south. The income, health, education, and housing levels are far below the City's average. There are over 400 abandoned houses in this 90 block area, and over one-quarter of the habited homes are considered substandard and overcrowded. Statistically, Mantua presents one of the bleakest pictures of a ghetto in the city.

As is true in all aspects of life, the poor are provided with the least services. Mantua is served by the 16th District of the Philadelphia Police. Patrol cars are generally seen only along 33d, 34th, Lancaster, Haverford, and Spring Garden Streets. The police are slow to respond to emergency calls and complaints—if they respond at all. It is generally assumed that the police want to get involved as little as possible with the community. There are community relations meetings at the Police Department at which attendance is good — about 30. Nothing seems to come out of these meetings, and the establishment's answer is generally, "Of course we'd like to help in this matter . . . if only we could get a larger appropriation . . . already we are 2,000 complaints behind . . . why don't you people use your 'political pull' by banding together."

The PTC runs the 31 bus through Mantua; its schedule is sufficient, but its route avoids much of Mantua. Few in Mantua have automobiles. Trash and garbage collection is but once a week and is totally inadequate for such a densely populated area. (Most areas of the city have one trash collection and two garbage collections in a week.)

Stores for the most part are marginal owner operated corner grocery and variety stores. There is one large, clean, moderately priced Thriftway on Haverford Avenue. There are several large stores proximating Mantua on the west. These are on Lancaster Avenue. There are many bars in Mantua, most of which are run for absentee owners by local bartenders.

There are several schools in Mantua. The McMichael School is the largest elementary school in the East Coast. There are also a Catholic School for the Deaf, the Belmont Elementary School, and the Mantua-Powelton Mini School.

Recreational facilities are provided by city operated playgrounds and Tot Lots. These are in fairly poor shape and unsupervised except for McAlpin playground. Mantua Community Planners has converted two city parking lots into basketball courts. MCP runs several basketball leagues on these courts. Several pocket parks are in the process of being built by the Mantua Workshop and the Mantua community. MCP and Young Great Society and Haverford Center all maintain recreational programs for Mantua youths.

In Mantua there are three general practioners and one dentist all of whom take DPA patients, but they have very limited hours of practice. (Each averages about four hours per day.) The community turns to these men only in emergencies.

On June 1, Young Great Society established a medical center on 33d Street. Though it appears to give very adequate emergency services, it is not used by the majority of the community due to: 1. lack of publicity; 2. location; 3. the stigma associated with the name YGS. In essence, YGS Medical Center is just what it says — a YGS facility. It can not be considered a community project or facility.

Mantua is also served by District 4 Health Center. This center is already burdened in its district of 200,000 people, and is located quite far in walking distance from Mantua. District 4 is not served by public transportation convenient to Mantua. District 4 does not seem interested in reaching out to the community either.

As much as I hate to admit it, health is not the major priority in Mantua — jobs, education, housing, and the elimination of police brutality certainly are much more essential to improving the daily life in Mantua. Some of the health problems are (in order of priority): venereal disease, mental health, physical health (comprehensive medical care), alcoholism, drug addictions, tuberculosis. Unless education and living conditions improve at the same time, any improvement in health care will be minimal and temporary.

An effective attack on the problems of health care is impossible without a simultaneous and comprehensive attack on all the social and economic conditions which breed poverty and illness. It is perhaps for this reason that community involvement in the planning of comprehensive health care services has been minimal — a more pressing need is shown in the assault on the problems that bring about poverty. We have been involved with legal, housing, and zoning matters. We have done some research in the planning of V.D. clinics, mental health clinics, and physical health clinics, but this has been apart from the community— we are writing proposals that we think may be effective in Mantua.

There is only one way I can see as a viable means of getting things done — that is by direct action. This may be in the form of harrassment, picketing, or by doing it yourself. Whatever the tactic, in an underdeveloped community it is impractical for one to believe that either the city or the grass roots members of the community will undertake action without a slight amount of encouragement.

After a discussion with a member of the Mantua community, I realized that the incidence of venereal disease in Mantua was unusually high. This was due to lack of health education, crowded living conditions, and lack of an adequate treatment facility. (The closest facility is at 500 South Broad Street.)

A meeting was arranged with Dr. L., the head of V.D. Control, and I proposed that his department (V.D. control) establish a clinic in the Mantua area. Dr. L. felt that this was impractical since people do not want to be seen walking into a "V.D. Center." An alternate solution was proposed — part-time facilities should be set up in District 4 at 4400 Haverford Avenue. Though this center is not in Mantua, it can be reached by walking. Also, it was suggested that the city supply public health educators in Mantua to provide hygiene education and to publicize the new V.D. clinic at District 4.

It was asked that the President of Mantua Community Planners write a letter officially requesting that the city establish more V.D. facilities. This was completed in the middle of July.

The next move was up to the Health Department—once a week I received a call from the Senior Public Health Officer who informed me that he brought the matter of establishing a V.D. clinic in Mantua to a meeting of such and so and that he felt quite sure that a facility would be established shortly.

I have been receiving this run-around for four weeks now — I've received calls of encouragement that it was only a matter of a short time, I've received letters ("We are currently dealing with this request"), and I've even been visited by the coordinator for several health districts. But results are all that counts . . . and there is no V.D. facility at District 4 yet.

A community mental health program has also been devised. This was originated by a psychiatrist at District 4, and has since been modified by work done this summer. Ideas for modification of the original proposal arose from discussions with psychiatrists from Temple Community Mental Health Center, the City Department of Health, and several psychiatrists in private practice. The proposal as it stands now is an amalgamation of their ideas that have been modified to fit the community's needs as I see them.

Basically the source of patients for this center comes from many "informers" in Mantua. These may be neighbors, block captains, bartenders, gang workers, civic leaders, or corner store owners. They advised the troubled person to seek further help at the mental health center. At the center there are several indigenous workers and a staff psychiatrist who shall select out those patients who need intensive treatment, sending them to facilities that exist in the city. The remaining patients will be dealt with at the center using group and/or individual methods.

Mantua and Mantua Community Planners (II)

SHO workers in the Mantua Community Planners project have grappled with the issue of helping Mantua plan and develop community services for the people of Mantua. The Mantua Workshop is the community institution doing the planning, serving as the active liaison between the people of Mantua and the City, directing the research, providing the technical skills — and harnessing white energy and concern. It is within this community organization that our work has been done. The legitimacy and credibility of the planners and the workshop as effective community organizations largely rest on their indigenous character. Hence, SHO students have assumed an "invisible" role, behind-the-scenes and supportive, developing proposals rather than a "visible" role on the streets doing anything like active community organizing.

From the outset, SHO, as a matter of principle, has consciously placed itself in a subordinate position to community groups. The preceptor, speaking for the community, raised the issues, identified the problems and directed SHO workers' activity. Thus, SHO attempted to prevent still another white middle class organization from flooding the ghetto with its own values. However, our preceptor's first question was, "What do *you* want to do this summer?" "What are *you* interested in?" In reality, the process of defining issues has been somewhere between these two positions. It is fair to say that the community wanted action in various areas, although the preceptor and SHO workers really verbalized the issues and defined the problems. Our preceptor suggested ideas. Our process of research was essentially one of gaining an overall appreciation and sensitivity within the problem areas, then focusing on one aspect and narrowing our inquiry. Our object was to produce concrete, functional, empirical statements for community action rather than general theoretical "analyses."

Our projects have varied from individual to individual. Most of our research has been done separately. The students have communicated more than the community worker and youth intern. Our work has been tailored to our individual skills and interests. Again, much of our effort has gone into preparing feasibility proposals for specific projects. The projects will be implemented by the people of Mantua and for the people of Mantua. Much of our "research" has involved talking with key residents of Mantua. Another large part of the research has been establishing contact and then negotiating with city officials — both in public health and in other fields such as housing, the police and elected officials. A third part of our inquiries took us to useful resource persons outside Mantua and outside the web of city government — to health professionals, lawyers, and other experienced people. Only a small part of our research took place in the library.

The following is a brief run-down of our projects. In some our part is completed; in others it is just beginning.

1. *Mental Health:* Development of a proposal for a "Trouble Clinic," a walk-in clinic utilizing indigenous workers — bartenders, cornerstore owners, gang workers, barbers, community leaders, and recreation workers—as "listeners" and as counselors to handle threshold problems and as liaisons to the storefront clinic. These "listeners" would operate in the community and refer individuals to the clinic. Within the clinic would be located a psychiatrist, medical services, a lawyer, vocational services, and experienced community personnel.

2. *Comprehensive Medical Facility:* A proposal is being written for a community medical facility, hopefully serving all of Mantua. Located in a rowhouse it would break down the barriers—transportation, size, whiteness, impersonality — between Mantua and the surrounding medical institutions.

3. *TB Examinations:* On two occasions, SHO workers scheduled the City's TB mobile unit for visits to Mantua. Sites were selected, publicity was prepared and distributed and recruiting was done a personal basis. The target group was composed of persons bypassed by other TB checks, i.e., those not in school and on jobs where periodic TB tests are scheduled. Approximately 200 such tests were given.

4. *Social Disease:* With community pressure a Venereal Disease Program was instituted at the District 4 Medical Center.

5. *Bail:* A feasibility proposal was prepared for establishing a community bail bondsman to serve Mantua. This would be a black businessman working to serve the community and in business for a profit. The proposal found the entire bail "business" to be dirty and a community bail bondsman a good idea for the future — 4 or 5 years away — rather than for now. As an alternative, a plan was designed to integrate the Philadelphia Bail Project into Mantua's needs. The Bail Project attempts to release defendants on their own recognizance in lieu of bail. The process requires close community connections to speed up the verification of information obtained from the defendant at the Detention Center and House of Correction. Thus, a system was devised using block captains as the persons to contact to start the verification process.

6. *Landlord-Tenant Problems:*

A. Individual Cases: Individual cases were referred to the SHO law student by various community workers—seven or eight cases altogether. Each case involved expediting the problems *with* rather than *for* the individual involved. The cases concerned landlord problems, insurance fraud, problems with the city Water and Tax Departments and problems with realtors. The cases led to good cooperation from Community Legal Services and isolated individuals within the City government—and apathy and hostility from the "establishment" as a whole.

B. Community Escrow Agent: Pennsylvania's rent withholding statute allows a tenant to divert rent from his landlord to an escrow agent when the city certifies the tenant's dwelling "Unfit for Human Habitation." A proposal was prepared to facilitate rent withholding using the Mantua Community Planners as an escrow agent. The plan involves close coordination with L & I (not very easy to obtain), immediate contact of tenants whose dwellings are "unfit" and negotiations with landlords to prevent the cost of repairs being transferred to the tenant in the form of higher rent. While L & I has been reluctant to cooperate, the plan will go into effect this fall.

C. Housing Clinic: A proposal is being prepared for a Community Housing Clinic to which residents with housing problems can come for advice and action. The clinic would provide a variety of services, e.g., directing an emergency repair unit, providing legal advice, running educational programs for tenants, action as an escrow agent for Mantua, giving advice on establishing credit and mortgage opportunities, providing a list of dependable contractors *from Mantua* to do repair work and rehabilitation and finally acting as a real estate agent for Mantua—locating vacant apartments, arranging home purchases, etc.

7. *Community Parks:* The community has started construction of several parks. Legal research has been done in the area of structuring effective community control and maintenance of the parks.

This is only a quick summary; much has been left out. It would be tiresome to describe individual encounters with the "establishment" and not really very illuminating. Not surprisingly, the establishment has been lethargic. Several individuals within the establishment such as Walter Lear, individuals on the City Planning Commission and individuals within Community Legal Services have been invaluable. On the whole, however, the city's attitude has been one of "disposing" of problems rather than "resolving" them.

VARIOUS MENTAL HEALTH PROBLEMS

Karen Lynch

At five sites, SHO project workers were dealing with problems of mental health. Three of these sites are represented in this section. Reports of the other two, Temple Community Mental Health and the Trouble Clinic of the West Philadelphia Community Mental Health Consortium, are presented in other sections of the report.

These articles discuss various aspects of the complex processing of mental patients from the point where they are first identified as "mental patients" to the psychiatric wards and then eventually back to their communities. The experiences of PSHO workers not only showed them the intricacies of administering this process and the problems of staffing, maintaining, providing, and coordinating services, but also involved them in the present reorganization of mental health services in Philadelphia.

Michael Geha was not simply involved in that process of reorganizing services in Philadelphia, but suffered the consequences of that reorganization process. The Jefferson project never really got underway for the summer, although they developed plans for an interesting, feasible project.

The entire mental health system of Philadelphia isn't disorganized, as the reports of two PSHO workers on one psychiatric service of Philadelphia General Hospital show. Harry Hirsch and Rich Bernstein present complementary points of view on their work with the Neighborhood Youth Corps on the recreation project.

Jim Padget and Steve Ager present an interesting account of their experience at Horizon House, a residence within the community for recently discharged mental patients. Their insight into motivations and the apparently simple problems facing these patients may lead to greater sensitivity in working with these patients.

None of these problems is new; the approaches in confronting them are new and serve here as examples for future programs.

Organizing Mental Health Services

Michael Geha and Gail Jones

When we arrived at our project site, we found a complete state of chaos. The entire mental health set-up in Philadelphia was being reorganized with a new program taking effect July 1, 1968. Changes in the physical plant as well as in the personnel were in high gear. Needless to say, little thought had been given to the PSHO project After meeting with Mr. J. it was obvious that the only real planning was that which produced a letter to Ron Blum and an arrangement for a two o'clock appointment with Dr. W. at Philadelphia General Hospital. When we arrived there, we waited hours for him to show up. As it turned out chaos existed at the Philadelphia General Hospital too. The entire Jefferson Hospital service had been moved from the seventh to the sixth floor along with a complete shift of the staff, including a new nurses staff and new interns and residents. By the weekend we had little in the way of a project. Everyone was very interested with words only, including suggestions as to whom, except themselves, would be best suited to help us with our project. All we needed was someone to spend a few hours giving some direction. On Tuesday of the second week we found someone who was interested, Richard S., Ph. D. With him we set up a structure for a project. This structure is described in the proposal which is appended to this paper. Once this was done, we began to cook with our project. Three weeks later we were deflated, depressed, and very unhappy because we were only able to find two or three patients who fit into our structure. As I look back now, I realize what went wrong. The most crucial point, because there are many, is the fact that our ideas were molded into a project by a man who had just arrived at the PMHC, and who knew less than I about the Jefferson catchment area and what was going on at Philadelphia General Hospital. We knew what the ward at Philadelphia General Hospital was *supposed* to have in the way of patients, but not what it actually had. If the mental health community was operating as it is designed to operate, our project would have worked. What I fail to understand is why Dr. M. and Mr. J., both of whom knew exactly what was going on, failed to realize what would happen if we tried this type of project.

What I'm trying to say is that the idea we had was excellent, but not resolute with respect to what kinds of patients are in the Psychiatric Ward at Philadelphia General Hospital. What has become obvious to me is that most people know what is supposed to be going on, but there is such a total lack of communication between people that no one knows what is really going on anywhere but right where they themselves work. Thus, Dr. M. had no idea we were coming in the first place, Mr. J. didn't know what the patient situation was at PGH and poor Dr. S. had not been in the community long enough to know anything but what he had read about it in the appropriation for the staffing grant. The lack of communication came out even more sharply when he attended a staff meeting of people from all the different agencies involved in community mental health in the Jefferson catchment. No one knew about anything in the other agencies. Service was being unnecessarily duplicated, resources unused in one agency were needed badly by another, but because no one was "aware" they were unused.

I don't think there is any way to summarize except to say that everything just "happened." There was little planning and thought put into *our* project. Gail and I tried, but we know much too little about community work or for that matter even what it consisted of, to know which way to go, and as we tried we could get no one to tell us what was going on and which direction we should take (this may have been because no one really knew). My opinion is that unless the public mental health election this fall and Jr. Corps Service at PGH proves outstanding for Jefferson students this fall, the project site should be abandoned as a project next summer. If it is not dropped, a lot of work should be done at the start of the project preparing some type of informational data for the project worker so that they know what is in the community and the services provided by the agencies.

Proposal: Summer Training Program for Medical School Students

Goals

This program is designed to give students an opportunity to study a series of mental patients over an eight week period during which time these patients will be making a readjustment to their families and communities following release from a mental hospital. A secondary goal is to gain some feedback from the students regarding two subdivisions of the Jefferson Catchment area: the low socioeconomic Negro ghetto (area B) and the low socioeconomic white ghetto (area C).

Procedure

It is requested that Dr. Mock at PGH, or members of his staff, refer to the summer students a total of 20 patients who are preparing to return to their homes. Hopefully this sample of 20 patients, ten in the two designated subdivisions of the catchment area can be located one week prior to their anticipated release from the hospital. Students then will review the case records of each patient in regards to demographic characteristic, personal history, previous alienations and symptoms of present psychosis. Students will interview each patient to get acquainted with the patient and to learn his plans for leaving the hospital and for reentry into the community. Students will also visit each family prior to the return of the patient to the family homes. The interviews with the families will be directed towards learning about the family's previous experiences with the patient, their expectancies in regard to the patient, and their areas of acceptance or rejection of the patient. In addition to a description of the family situation, students will complete items 22-30 of the Freeman and Simmons questionnaire. They will also study the community setting to which the patient will be returning and in addition to a description of the community in terms of relevant variables, also describe the relationship of the family to this community.

Following the return of the patient to his family, the student will interview the patient in the family setting, one, three, five, and seven weeks after his arrival there. The interview will consist of items 1 to 21 on the Freeman and Simmons scale. Relevant items will be administered to the patient and also to the significant family member. In addition, the patient will be rated on the MAAC scale and the Overall-Gorham Scales.

At the end of the seventh week, after all interviews have been completed, the students will summarize the changes over time that he has noted in the patient and also his impressions of the barriers to further growth, whether they derive from the patient himself, from the family or from the community setting. This last item, hopefully, will give feedback to the Jefferson Community Mental Health Center regarding community factors in areas B and C which influence the mental health of the residents.

The Recreation Project for One Psychiatric Service: Two Points of View (I)

Harry Hirsch

Problem

Prior to this summer, no program of recreation therapy existed for the 80 in-patients in Penn's Psychiatric Service located in Philadelphi General Hospital. Patients were able to spend their time watching TV or staring at the wall—neither of which is particularly therapeutic. As part of a series of moves designed to upgrade the quality of psychiatric care at PGH, a pilot recreation program was suggested for the summer, with successful aspects to be maintained throughout the year. The widely varying interests of the patients, who ranged in age from 10 to 80 years presented a challenge to anyone planning an activity program.

Resources

The Mental Health Consortium had engaged five supervisors (of whom three were SHO workers) to work under Christine Westfall in planning and executing the recreation program. Thirty high school students from the West Philadelphia area, working in the Neighborhood Youth Corps, were paid $1.40 an hour by the Youth Corps to serve as recreation aides. All but two of the recreation aides were female. A Consortium sociologist led semiweekly inservice training seminars for the five supervisors and preceptor. He also served as a valuable advisor and consultant on sundry problems arising during the summer. The seminars dealt with the background of mental illness and practical problems encountered in group work.

In addition to these human resources, the physical facilities available proved to be adequate for the program needs. Several grassy fields on the hospital grounds were used for outdoor activities. The PGH recreation department and a small budget from the Consortium provided athletic and indoor game equipment. The Consortium bus was used for trips to the zoo, Phillies games, and weekly swimming excursions at League Island Pool (Philadelphia Recreation Department). A request to use a beautiful indoor pool in the nearby PGH nurses' residence was turned down by the "matron"-in-charge.

Organization

Each of the five supervisors worked directly with a team of recreation aides. Because the need for recreation activities is, in fact, greatest on evenings and weekends, when hospital routine is at a minimum, the program operated on a seven-day week: 1 to 9 p.m. Monday through Saturday; 9 a.m. to 9 p.m. on Sunday. Two teams of recreation aides and two supervisors were on at any given time within that schedule. These arrangements resulted, for supervisors, in a week of approximately 35 hours and 2 days off out of every seven.

Activities

Structured activities comprised one aspect of the program. These included bingo, picnics, movies, bowling, volleyball, softball, trips for swimming, museum, zoo, baseball games, and arts and crafts. Poetry readings and psychodrama were used a few times. Much of the program consisted of unstructured relating to the patients. Card games, checkers, ping-pong, and above all, discussions among patients and recreation workers filled out the unstructured time slots.

Success in Confronting Problem

The recreation program succeeded fairly well in supplying a varied schedule of recreation activities. Moreover, the program provided enormous opportunities for patients to participate in social interaction and thus facilitate their recovery. Because of common socioeconomic backgrounds, the Neighborhood Youth Corps workers were able to relate quite well and without inhibitions towards many of the patients.

The success of the NYC workers in this project is significant in terms of meeting personnel needs in health care delivery. The successful employment of inexperienced recreation aides (and supervisors) in the recreation program suggests that people lacking formal training in medical fields may, nevertheless, be able to free trained personnel for more efficient use of manpower.

A major criticism of the recreation program is the failure to establish a routine activity schedule. Supervisors planned activities on the spot. An activity schedule would have provided a structure on which supervisors could fall back on when in doubt of what to plan, and would have insured a more varied array of programs than was actually offered.

Closer communication between SHO and project preceptors would have been helpful in ascertaining the role of SHO workers at the project sites. The 7-day working week was both a basis and subject of conflict. SHO workers were not prepared for the "cruel and unusual" summer work schedule which was not suggested in SHO advance publicity or project descriptions. The schedule was handed to supervisors at the beginning of the summer as "what *had* to be" and was accepted largely due to a lack of viable alternatives. The working schedule resulted in conflicts between site obligations and SHO meetings, conferences, and programs. While I generally placed my allegiance to the project site above that towards SHO, the other two SHO workers tended in the opposite direction.

Relations with the PGH staff were, for the most part, extremely cordial. The R.N.'s and P.N.'s were very cooperative and often assisted in urging patients to participate in recreation activities. Male attendants were very friendly and often participated in the activities themselves. The female attendants, on the other hand, were usually both lazy and insolent to patients and were often uncooperative. Interns and residents seemed pleased with the program and were willing to confer with supervisors about problems in dealing with specific patients. Some initial conflict arose between the student nurses and recreation aides. Some student nurses were resentful (and perhaps jealous) of the rapport which the NYC workers had struck with the patients. The student nurses, despite or because of, their psychiatric training, often felt less confident in dealing with the patients than did the NYC recreation aides. By mid-summer, however, this conflict had been resolved. Whenever possible, supervisors attempted to involve hospital staff in the recreation activities. These efforts paid off in dividends of enthusiastic cooperation from most of the staff.

The patients tended to refer to the recreation aides as "volunteers." This term suggests that patients perceived the Youth Corps as people who enjoyed relating to the patients rather than workers who put up with drudgery in order to collect a pay check. Patients appreciated the presence of people who: (1) took time to stop and listen; (2) broke the monotony of a hospital stay, with planned activities; and (3) were, at first, easier to manipulate than other hospital staff. Patients were particularly glad for opportunities to participate in off-the-ward activities. Some effort should be made, however, to decrease their dependency upon the recreation staff as the only source of organized recreation and help patients to organize their own recreation programs.

Conclusions

Although this project failed to confront any major injustices of the health care system, the establishment of the pilot recreation program succeeded in filling a major gap within the present system. This site afforded me the experience of relating to: (1) psychiatric patients, (2) "hard-core" ghetto youth, and (3) the bureaucracy of a large city hospital. Finally, the problem of transferring the program into the hands of the year-round staff remains to be confronted between now and the summer's end.

View II

Richard H. Bernstein

The group which our recreation program came into contact with was the Neighborhood Youth Corps. This group of underprivileged black high school students was a constant source of fun and difficulty. Formally, the 25 young people (two of whom were boys) were divided into five teams, each headed by a white supervisor (three of whom were in SHO). Each supervisor was supposed to encourage his team to get the patients involved in some outdoor activity or, if we were on the ward, to engage in quiet indoor games. Talking to the patients and relating to them spontaneously was very much encouraged by most of the supervisors.

Despite the admonitions of black nationalists and militants, we found virtually all of the NYC people receptive to our friendship and our leadership. Even when actual resentment toward certain supervisors did arise, the black students candidly denied any feelings that a given supervisor was condescending or taking advantage of his authority, they were quite surprised to hear and quickly dismissed the possbility that the supervisor was expressing a white supremacist attitude.

Regarding the effectiveness of the NYC, I have mixed feelings. Relating to patients is difficult. It is very easy to ask people to "just talk to anyone who looks alone." But these young men and women have had no previous experience in a psychiatric setting. Furthermore, they find it very difficult to carry on a conversation with adults in their own community, let alone in a community of emotionally disturbed adults. As a result, the NYC students *tended* to gravitate toward the younger patients, and more particularly, to those patients who were not physically repulsive nor verbally hostile. On the whole, the patients who received the greatest amount of attention, were under 30, black, and white males, extroverted or passive men who were receptive to and thankful for the attention of the girls. Thus, almost a third of the patients received a lot of direct attention from the NYC. It should be noted that this is only a generalization, for certain members of the Youth Corps felt very much at ease with the less sociable men and women of all ages.

If an index of success for the recreation program was direct, personal contact between Youth Corps and patient population, our program has failed. While it was hoped that, as the students became more at home on the wards they would socialize more freely, this never materialized to any large extent. Even at the end of the summer, it was somewhat common to find three recreation aides (i.e. NYC members) and only one patient playing cards together or to observe three or four recreation aides watching TV or sitting alone without patients nearby.

Despite this fact, I was very interested to hear that an experiment in Europe indicated that wards in which there were community adolescents present had a higher rate of discharge and absence from in-patient services for *all* ages of patients than control groups. Therefore, it might well be that even if the recreation aides dance and talk among themselves, sit alone, socialize only with the men, or just generally do their thing, the old ladies and sick old men are absorbing the atmosphere, which simply radiated with life and health and youth.

Health Problems

After discussing with others, it seems that the fundamental problem with the health care delivery system as far as I saw it (on the eighth floor of the Mills Building run by Penn), was that Penn is much more concerned with educating its interns and residents than with treating patients. The treatment aspect is not absent, of course, but various conditions on the ward indicate that Penn is educationally oriented. Most critically, it is clear that there is hardly any semblance of a team approach to patient treatment. If the medical staff in charge of the ward were truly interested in helping patients, they would institute, as early as possible, a team approach. This would involve cementing the nurses, student nurses, attendants, social workers, and recreational and occupational therapists into a working group to serve as the surrogate eyes and ears of the doctors. The above staff should be informed about the patients' history and, more importantly, should be aware of, and have some say in determining the staff's "strategy" for each patient. As more and more observations in various settings are made, the strategy may be altered. But in any event, the doctors ought to have some communication with the rest of the staff if they are to make the most efficient and prudent use of the human resources latent in the staff.

In the ward setup, the doctors consulted with the social workers, although I am not sure how often. Over half the doctors' time was spent learning about patients from their teachers and fellow residents. Doctors read the nurses' notes on patients; however, charting was only done when there were some fairly dramatic changes in the patients' physical or emotional or behavioral condition. Pertinent conversations or observations made by attendants or our recreation teams or supervisors were not discouraged but never really encouraged. We, the recreational program, felt very much alienated from the nursing staff in so far as giving our personal opinions. While nothing was said, I felt my observations were listened to but not openly welcomed. I should say, however, that several nurses did spend some time with the supervisors, informing them about patients.

Perhaps one of the most illustrative examples of the attitude prevalent this summer among the staff was demonstrated at the very first meeting we supervisors had with the ward staff. We five met with the head of nursing, the head of student nurses, and someone from social service. They made it quite clear to us that the recreation program was our baby and that we could not expect and should not expect any help from the staff, because of the terrible burden they had with other things. This is a striking example of the way communication is discouraged, resulting in a fractionating of a potential team effort, and ultimately in causing poorer care to the patient.

Resources

The most obvious recommendation I have is to encourage the Consortium to put pressure on University of Pennsylvania Medical School to institute a team approach to dealing with patients. This would mean coordinating the efforts of the heads of student nursing, ward nursing, social service department, the recreation and occupational therapy department, so that all working together in order to both promote educational instruction and maximum care for the patients (through a team effort). Furthermore, Penn ought to get more psychiatrists working on the ward. At present, about 90 percent of the doctors are interns and residents, who spend about two-thirds to three-quarters of their time in classes or in clinical conferences. Lastly, it seems that the Consortium should act as a consortium of several medical schools' services. As far as I could ascertain, there was no coordination of efforts and resources between the various floors (each run by different local medical schools). Apparently, the known political rivalry among schools has been allowed to be expressed within the rubric of the "Consortium." Each floor is a perfectly autonomous unit, totally segregated from the others. This must inevitably lead to inefficient use of resources and poorer delivery of services to the community.

Horizon House

Steve Agar and Jim Padgett

Can you imagine yourself being away for 5 months, 3 years, or even your life time from the society that you've been used to? I can't either, but several people whom I have met this summer have faced this problem. What are these new buildings they see? The strange new dress? The changing political and social world? Can you put yourself in their places?

This has been the plight of most of America's mental patients. Our system of mental health care has been what we thought was quite professional and indeed it was for its time, but now the situation is no longer the same. A step back into the *community* must be made in the clinical *treatment* of the mental patient. He should no longer be shipped out of his home territory into an impersonal, factory-like environment from which he will eventually emerge, somewhat a stranger to his former situation.

A recent research project in which we have been involved deals with the product of such a system. We are trying to motivate ex-patients (called "members" at Horizon House) to learn about and search out their communities. We have divided a low-functioning class of members into three groups of 10. One group is a control. With both of the other groups, we discuss various activities, such as the Franklin Institute. One group of people is urged to go to these community activities by itself (client-led) while one of the PSHO students takes the other (staff-led). In this manner, we may be able to show which, if any, is the better method to get the clients involved in the community.

As the project has just begun, we have no results as of yet. But the ultimate knowledge gained will not be concerned with which method is better. The result of this project will aid members treated under the present mental health system; but the final question is, "Is this system adequate?" We think not.

Thus, we have a difficult time getting J.R. even to go with the staff-led group. J. wants to go in order not to hurt our feelings, but his convenient sore feet, early rising hours, various duties, etc., prevent him from joining the poorly attended group trip.

Therefore, our duty of motivating these people becomes a very difficult and trying job. Are we convincing enough while telling them of our exciting trip the following day? Should we pressure them into coming? These questions and this research project wouldn't be as necessary if these chronically ill people had been hospitalized short term in their own communities.

In addition, a series of social functions for male and female ex-mental patients was established at the Horizon House residence, which was very successful. Unfortunately, a proposal to initiate a concomitant series of sensitivity groups to enable the boys and girls to better understand each other's motivations was squashed by the powers that be for irrelevant reasons.

This whole new field of community mental health is finally beginning to take shape and results are coming forth. We never realized the consequences of our country's antiquated mental health program until this summer. Now we can see.

PLANNING AND DEVELOPING PROGRAMS

Karen Lynch

Each project and each new program which is developed in an attempt to achieve that long-range goal of improving health services is unique. Yet, the successes and failures of the past are brought to each new project and these experiences should guide future plans. Four such experiences are included in much detail here. They should be read not so much for the case history of one proposal or one program as for the successes and failures which each one faced along the way and the action which was taken in each case.

At Southwest Center City Community Council, project workers and community people knew the general needs of the area, but worked in several different directions until they finally decided to write up a proposal. The Delaware County project involved two students preparing for the November election and the county health department issue which was on the ballot.

These two sites were involved in planning. The project workers at Citizens Concerned for Welfare Rights were setting up a babysitting center and then presenting proposals to various organizations for funding. At St. Chris, a photography club was set up with a dual objective: it educated children during the summer and it was a means of entering the community. A careful reading of these papers should provide both information and a feel for the effective approach to establishing new community programs.

Changing Direction at SWCCCC: From Survey to Proposal

Ed Pisko

There are two health science students now working with the Southwest Center City Community Council (SWCCCC) at present, Carla Oswald and Edward Pisko. A member of SWCCCC and its Health Committee is working closely with these students.

The Initial Role of SHO Workers

The initial agreement to bring in the students was made between Mr. C., representing SWCCCC, and the SHO. This agreement was made with the knowledge and approval of the Health Committee and the Executive Board of SWCCCC. Mr. C. was to serve as preceptor, defined by SHO as "an individual, usually a professional, who is responsible for the activities of the project workers at the project site. He will meet with the workers regularly and offer guidance and assistance, while not directing the actual activity of the workers."

The roles of the workers were not clearly defined by SHO or SWCCC. At first, it seemed that their role was to do a health survey of the SWCCCC area west of 19th Street. The reason for this was to help in obtaining a children's clinic and program similar to the one in existence in the eastern SWCCCC area, the Rebound Program.

After discussion, a questionnaire was compiled using many of the same questions that Dr. L., Director of Research, had used to obtain information about the persons Rebound was serving. Other questions were added that seemed pertinent, and the questionnaire was submitted to the Health Committee and approved after suggestions were made.

However, before they started surveying the community with the questionnaire, they decided to see if this was the best way possible to deal with the problem of obtaining health facilities. Dr. L. revealed that her questionnaire was used to gather information that would help administer and evaluate the program that was already funded. But in order to obtain a grant for new facilities, the proposal should contain statistics from the Census Bureau, the Philadelphia Department of Public Health, Philadelphia School District, Department of Public Assistance, and police records. Therefore, a health survey would not be of great value at this time.

Health Care System

The next move was to see how one goes about obtaining a health clinic for an area, since it became evident that a health survey was not the answer. Since the original goal of the project was comprehensive children's health care, the idea was expanded and research was done into comprehensive health care in general. This decision was also based on changing concepts about what is considered good quality medical care.

These are changes which can be seen right in this community. To begin with, one reason that the two hospitals are going to leave the area in the next few years, is the belief in a health center complex as the best way to administer hospital health care. To the University of Pennsylvania, who owns the two hospitals, there is a great deal of value in putting the two hospitals with others. Some of the advantages of this system are the close proximity of a large number of physicians for consultation, centralization of facilities, and proximity of the medical school to its associated hospitals. Temple University has a similar program with a large health center complex being the anticipated end result. It is of interest that Temple has also established a comprehensive health center in the community of North Philadelphia.

Group practice is considered a model of quality in the field of medical care. Its emphasis on having many specialists see a patient guarantees high quality care. In combination with a good hospital for in-patient services, a person can be assured of the highest quality treatment for illness under the group practice system. The comprehensive health care program in cooperation with a good hospital provides this same model of care, but with even more services than the group practice hospital model.

The Present Health Care System in the SWCCCC Area

There are many means of obtaining health care in the SWCCCC area. These include private physicians and hospital clinics. However, at present the main concern is the services that Graduate and Children's Hospitals provide. These services include in-patient (hospital bed) and outpatient (clinic and emergency) care.

1. *In-Patient Care:* Children's Hospital has always provided quality in-patient care, and with their moving to new facilities these services will probably improve. It would be expected, then, that many people would continue to go there despite the distance. The alternative is the erection of a new hospital in the

SWCCCC area, or renovation of Children's. The advantages of such an institution would be many. If the hospital were community controlled, the hospital could employ many local residents and train them as nurses and other health personnel. Funding would be a problem. Mercy-Douglas and the University of Pennsylvania has been mentioned as possible sponsors of the hospital. The city could also be approached as a sponsor, but community control would then be difficult. The City Department of Public Health is still mainly concerned with preventive medicine and not with treatment, although this philosophy might change when funds are available.

2. *Out-patient Services:* The present system of waiting for hours in a hospital clinic is faulty. The service is very often impersonal and the followup is poor. If the community decides to have its own hospital, and it wishes to incorporate out-patient services into that hospital, it is important that the unsatisfactory qualities of hospital out-patient clinics be eliminated. The alternative is an out-patient facility which would provide emergency and treatment facilities and be housed apart from the hospital. The Federal Office of Economic Opportunity funds comprehensive health care programs, and the program could be set up to serve all the people in the SWCCCC area.

Advantages of Comprehensive Health Care

The acceptance of the Rebound Program which provides comprehensive services to children in the eastern SWCCCC area demonstrates the value of this service to the community. The Rebound Program could be incorporated into the larger program that serves everyone. The comprehensive health program is a combination of two concepts in the practice of medicine. The program provides for a primary physician who acts as a family doctor. In addition, there are other specialists on call and this provides the advantages of group practice. Arrangements would be made with a hospital for in-patient care when these services are needed. The program provides for a great deal of involvement of the community in the planning and running of the program. The present Pennsylvania Hospital program provides for complete community control after three years. Therefore, whatever programs the community wished could be incorporated into the program including training of community people as nurses and health workers.

Present Philadelphia .Comprehensive Health Care Programs

There are presently two comprehensive health care programs in the city of Philadelphia. Mr. Robert Fishman wrote the proposal for the project sponsored by Pennsylvania Hospital, and the proposal is available for anyone to read in his office. Mr. James Snipe, of the Temple Comprehensive Health Program, completed the proposal for the comprehensive health program there and he may still have copies of his proposal available. The students have talked to both of these gentlemen and certain things were emphasized.

Mr. Fishman spoke of two alternatives for obtaining a comprehensive health care program. One alternative is for the community to write a proposal and submit it to the OEO office to obtain a grant. The United Neighbors Settlement House tried this in 1965 and they failed to obtain a grant. This year Mr. Fishman wrote the proposal for the community in affiliation with Pennsylvania Hospital and obtained the grant.

Mr. Fishman's suggestions on obtaining a health center were first to interest an institution in the area and then to work closely with that institution in writing the proposal for the comprehensive health program. The existing Health Committee or a subcommittee of the Health Committee could be the agent working with the institution. Mr. Fishman mentioned that the SWCCCC area falls in the boundaries of the Jefferson Hospital Mental Health Program. Therefore. a comprehensive health program would be a logical extension of those services. But Children's Hospital, as a part of the University of Pennsylvania is also involved in the area with the Rebound Program. Therefore, they should also be approached as a possible sponsor. Hahnemann, Mercy-Douglas, and the City Department of Public Health are also possible sponsors.

Mr. Snipe confirmed what Mr. Fishman said. He added that from the very beginning it was important to work with the Area H Anti-Poverty Committee and Community Action

Council, since proposals will have to be approved and submitted by these groups. Also in his proposal he mentioned the importance of working with city agencies concerned with health and welfare and state agencies of health and welfare, and community physicians and dentists.

Writing a Proposal

Initially a health survey was going to be done to establish the need for a comprehensive health program. However, if a proposal for a health center is written, existing statistics are usually used. The following section shows statistics demonstrating the need for a health center. These figures could be expanded with Philadelphia Department of Welfare, School District, and Police Records.

Sources

Although the members of the Southwest Center City Community Council (SWCCCC) and other residents of the SWCCCC area are generally familiar with the characteristics and problems of the area, a statistical description better documents the needs and makes it possible to objectively compare the SWCCCC area with the rest of Philadelphia. The original boundaries of SWCCCC—South Street to the north, Broad Street to the east, Washington Avenue to the south, and the Schuylkill River to the west—simplify this task. These boundaries almost exactly correspond to the outlines of the three census tracts which comprises this area—30-A and 30-C in the eastern SWCCCC area and 30-B in the western part.

Thus, the census data from 1960 can be used for general information about the population characteristics, income, employment, and housing. Although this information may have changed to some degree since the 1960 census was taken, it is presumed that it still represents the area to a great extent. Health statistics data are available from the preliminary Philadelphia health statistics for 1967.

Population

The population of all three census tracts is predominantly Negro. The percentage of Negro persons in the area is over three times the percentage for the city as a whole.

Table 1.—1960 Population Characteristics for SWCCCC Census Tracts and Philadelphia.

	30-A	30-B	30-C	Philadelphia
Total population	7,220	9,240	7,067	2,002,512
Percent Negro	96.8	82.8	98.4	26.4
Percent white	2.7	16.9	1.4	73.3
Percent other races	0.5	0.3	0.2	0.3

Income: Employment, Education, Occupation

The income level of the area is extremely low. Over a third of the families in the area have yearly incomes of less than $3,000. Over half earn less than $4,000 annually.

Table 2.—1960 Income for SWCCCC Census Tracts and Philadelphia.

	30-A	30-B	30-C	Philadelphia
Number of families	1,562	2,056	1,537	500,515
Percent under $3,000	40.0	36.9	47.9	17.1
Percent between $3,000 and $3,999	19.1	15.3	15.2	9.6
over	40.9	47.8	36.9	73.3
Percent $4,000 and				
Median family income	$3,525	$3,854	$3,139	$5,782

The median family income for the area is over $2,000 below that for Philadelphia as a whole. The average family size is 4.6 persons. These facts alone declare the need for low-cost, high-quality medical facilities in the area. Part of the reason for this low income is certainly unemployment. Unemployment rates for both men and women in the labor force in the SWCCCC area are double those for the whole city.

Table 3.—1960 Unemployment for SWCCCC Census Tracts and Philadelphia.

	30-A	30-B	30-C	Philadelphia
Percent of male civilian labor force unemployed	12.2	13.3	17.0	6.4
Percent of female civilian labor force unemployed	12.1	12.6	8.5	6.5

Further reason for the low income level can be found in the educational level and occupations of the SWCCCC residents. The area as a whole has a median of less than ten school years completed for persons 25 years or older. Overall, there are more than 300 blue-collar workers for every 100 employees on white-collar jobs in the SWCCCC census tracts. This is more than double the number of blue-collar to white-collar workers for the city as a whole.

Housing

While only 36.1 percent of the households in the entire city rent their dwellings, over half of the residents in the SWCCCC area rent their homes. This places an additional strain on the already very low income. Moreover, less than two-thirds of the housing units in the three SWCCCC census tracts are considered sound. Worthy of note is area 30-B in the western part of the SWCCCC community where 14.7 percent of the homes are dilapidated (defined by Census Bureau as not providing safe and adequate shelter; requiring extensive repair or rebuilding). Furthermore, over 10 percent of all SWCCCC residences are overcrowded with more than one person in the house for each room.

Table 4.–1960 Housing for SWCCCC Census Tracts and Philadelphia.

	30-A	30-B	30-C	Philadelphia
Percent of housing units owner occupied	17.5	40.7	18.9	58.7
Percent of housing units renter occupied	75.6	54.3	72.6	36.1
Percent of housing units judged sound	47.3	62.2	62.8	87.3
Percent of housing units deteriorated	44.7	23.1	35.1	10.6
Percent of housing units dilapidated	8.0	14.7	2.1	2.1
Percent of housing units with 1.01 persons per room or more	10.2	12.8	12.3	7.0

Health

More important than these facts are the obvious health needs of the people of the SWCCCC census tracts. With the poverty imposed on the residents already shown by all the above information, health problems place a further strain on incomes that have no room left to stretch. Health status is indicated below by statistics on birth, deaths, and incidence of preventable disease for 1967.

The live-birth rate in the SWCCCC census tracts is about the same or slightly lower than for Philadelphia as a whole (based on 1960 population figures). Although the birth rate is lower, the incidence of immaturity (weighing 5 lbs. 8 oz. or less at birth), congenital malformations (birth defects), and birth injury for these infants is substantially higher than for the city. The percentage of these infants born illegitimately is drastically higher in the SWCCCC area than for the entire city. This fact may suggest the need for sex education and/or planned parenthood programs in the community.

Many of the mothers in the SWCCCC area have inadequate medical care before the birth of their children. A mother's care is considered inadequate when she has no care until the last three months of her pregnancy or no prenatal care at all. The percentage of birth in the SWCCCC area preceded by inadequate medical care for the mother is nearly twice that for the city as a whole. This lack of care to the mother contributes greatly to the possible immaturity, birth defects, and birth injury of the infants.

Table 5.–1967 Birth for SWCCCC Census Tracts and Philadelphia.

	30-A	30-B	30-C	Philadelphia
Number of births	100	142	125	36,112
Birth rate per 1,000 (1960) population	13.9	15.4	17.7	18.0
Percent of live births immature	17.0	13.4	15.2	11.6
Percent of live births congenitally malformed	1.0	.7	4.0	1.1
Percent of live births with birth injury	....	....	1.6	.4
Percent of live births illegitimate	37.0	38.7	56.0	17.0
preceded by inadequate prenatal care	31.0	20.6	36.8	16.8

Death rates for 1967 are also substantially higher in the SWCCCC census tracts than in all of Philadelphia. Moreover, a greater percentage of deaths in the SWCCCC area is caused by preventable and infectious disease than in the city as a whole.

Table 6.–1967 Deaths for SWCCCC Census Tracts and Philadelphia.

	30-A	30-B	30-C	Philadelphia
Number of deaths	137	149	109	24,443
Death rate per 1,000 (1960) population	19.0	16.1	15.4	12.2
Percent of deaths from tuberculosis	2.2	.7	....	.6
Percent of deaths from syphilis	.7	....	....	.07

Table 6–Continued

	30-A	30-B	30-C	Philadelphia
Percent of deaths from influenza and pneumonia	3.6	2.7	1.8	2.8
Percent of deaths from nephritis and nephrosis (kidney disease)	.7	.7	.9	0.6
Percent of deaths disease of early infancy	1.5	2.0	4.6	3.6

These facts show that the SWCCCC area is a very impoverished area in its general characteristics and an area very much in need of more and better health care. The fact of Children's Hospital's relocation in 1971 has been established. This presents a vast decrease in the health services available to the SWCCCC community, while all evidence shows need for an increase. All the facts taken together indicate a critical situation in which the residents of the SWCCCC area must make some move to acquire an additional health facility in their area before 1971. There are various possible channels the community can take to reach that end but they all require action NOW.

What Is Public Health?

(Delaware County)

Jan L. Baxt and Sheldon A. Halpern

Positive physical, emotional, and social well-being, not just the absence of disease. In the simplest terms, "public health" is people banding together—primarily under governmental auspices—to solve health problems which they cannot solve alone.

Whenever two or more persons are affected by the same disease, this becomes a public health concern in the broadest sense. Public health services are directed towards the prevention of disease for all members of the community, while private health care is concerned with curing a specific illness in an individual. Private medicine and public health complement each other. The family doctor treats an individual case of hepatitis, while the Public Health Department traces down the source of contamination and eradicates it.

In brief, the responsibility of a Public Health Department includes:

1. Protecting you against disease, both chronic and contagious.

2. Controlling the environment so that the conditions under which you live, work, and play are healthful.

3. Finding those who need treatment and arranging for their care, if they would not otherwise receive it.

At the present time, public health services in Delaware County are administered by a multiplicity of governmental units and levels, in addition to the numerous voluntary agencies. Boroughs, First-Class Townships, and the City of Chester receive the majority of services from municipal health boards and health officers (38 in all). Second-class Townships and the two boroughs which have surrendered their programs to the State, are serviced by the State Health Department from its Chester office and the regional office in Philadelphia. In addition, the State consults with the municipal boards to aid in the problems when necessary, and has directed supervision over certain types of programs, which are primarily State responsibilities.

Introduction

It is an incontrovertible medical fact that in our complex society public health is a vital governmental service. The question remains, however: "Why should public health be administered on a countywide basis in Delaware County? We already have a State Department of Health Center and 38 municipal boards of health, as well as numerous voluntary agencies. Why do we need a County Health Department?"

First, it must be emphasized that a countywide administration of health services is not a new, untried experiment. Rather, it is the norm throughout the country. Eighty percent of the counties in the country are served by county health department. Delaware County, like many other counties, is undergoing changes which make the establishment of a county department both possible and more important:

1. A population boom is altering the nature of our community by:

(a) Quickly turning the eastern end of the county into a single densely populated unit with all of the problems which normally occur in areas of this type, and

(b) Accelerating the rate of development in the semirural western portion of the county.

Both areas require sound planning and comprehensive health programs to cope with these problems, but neither is possible under the existing fragmented municipal structure which bears little relation to patterns of work, trade, or recreation.

2. Increasing mobility of population, with people moving in and out of the county at increasing rate.

3. The accelerating pace of change and discovery in public health practices which requires the combined efforts of a team of trained specialists. All of the services and programs administered by a modern public health department are interdependent—when one portion of the comprehensive program is missing, all of the other programs become less effective. Providing the full range of public health services in a professional manner is beyond the scope of an untrained, part-time municipal health officer, and the fiscal ability of any one municipality.

Inadequacies of Municipal Health Departments

Let us now look at some specific reasons why municipal health officers, regardless of their diligence, cannot adequately serve the county's health needs.

1. Fragmented programs: In Delaware County approximately 75 administrative units are involved in the provision of official health services, including: 38 municipalities which have health officers and/or boards; the State Health Department, which serves the county through its Chester office and its regional office in Philadelphia; the various local school districts; county government, which administers a variety of services; and 11 other State departments engaged in various regulatory and supervisory activities. This is a cumbersome administrative structure without any central point for the coordination or integration of these closely related services.

2. Uneven quality: When there is great variation among local boards of health, *nobody* is really protected, because health problems overlap the boundaries of our small municipalities. How many Delaware County citizens spend no time outside their own municipality? Is there any municipality which prohibits entry to all nonresidents, The obviousness of the answers implies that everyone must be concerned about the quality of the restaurant inspections, communicable disease control, etc., all over the county—not just to be a public spirited citizen, but to be sure of his own and his family's health.

3. Untrained health officers: Experience has clearly shown that public health work is a highly professional undertaking. There is no substitute for professional and technical competence. As the Stebbins Report said: "Cheap public health is expensive—failure to provide adequately for the professional guidance of health programs results in inestimable waste."

With that in mind, consider the fact that there are no professionally trained and experienced public health directors operating in the county. The present municipal health officers range from salesmen or retired policemen to nurses, santiarians, and physicians, with varying backgrounds in public health. However, none of these have qualifications the State mandates for the Director of a County Health Department, namely, a physician who has taken postgraduate public health training, including a master's degree and a residency in public health and who is certified in the specialty of public health and preventive medicine.

It would seem that having a physician or nurse listed as a municipal health officer would guarantee a sound public health. However, this has not been the case. Upon consideration of the following facts, the reasons will become obvious:

1. Each of the 16 doctors who acts as a municipal health officer does so on a part-time basis; none is trained in public health work, which differs greatly from private medicine. Each is heavily involved in his own practice and is thus hard to reach in emergencies. Also, he is not usually available to participate in day-by-day planning and coordination of programs with other public and private agencies. Finally, by virtue of his office, he is potentially subject to serious conflict. If he is fearless, he is likely to lose some of his private practice. If he is timid, he cannot be a succssful health officer.

2. None of the 12 nurses employed as health officers are graduates of accredited public health nursing programs. As registered nurses,

all are trained primarily for clinic and bedside nursing, not for public health work in the community, especially sanitation.

3. Since the programs of municipal boards of health are concentrated largely in the area of sanitation, they rarely utilize the medical skills of the 28 doctors and nurses employed as health officers. Their skills and training would have much greater relevance in a well-rounded public health program which included the planning and administering of personal health services.

Part-time Health Officers

Public health has reached a degree of complexity in which the part-time local health officer is not able to discharge his duties as the executive officer of the local board of health adequately. It is impossible for him to acquaint himself with the many technical advances in public health and still find time to carry on his normal gainful occupation. Nevertheless, at the present time there are only four full-time, municipal health officers in Delaware County. Of the 39 municipalities with health boards in 1966, only four were paying their local health officers $2,000 or more in salary, six were paying between $1,000 and $2,000, eight between $400 and $1,000, and 18 under $400. Three reported no salaries at all under the local health officer category.

Spokesmen for municipal health interests herald their availability for nighttime emergencies. This obscures the difficulty of reaching many of these officials during daytime hours, when most people would avail themselves of their services. Besides, how beneficial is the presence of a public officer at midnight, if he is untrained? Few real public health problems emerge or can be dealt with on an emergency basis during these hours.

Poor Financial Base

A modern public health program is composed of many interrelated, highly complex, technical services which can be provided only by a trained staff of specialists. According to the Stebbins Report, an adequate financial base and minimum population of 100,000 or more are essential to provide these services efficiently. No municipality in the county could afford to provide the program and staff necessary.

Meaningless Boundaries

The boundaries of our small municipalities act as a hindrance where public health problems are concerned. Pollution, disease, and rate do not turn back at the township line, but a municipal health officer must. To combat public health problems, the entire county must count as one "community." Moreover, adjacent full-time county departments can cooperate more effectively than part-time local officials.

Small Range of Services

Many problems, such as rat infestation, lack of health education, and communicable disease, require a combination of professional disciplines and services. A county health department normally supports a range of these services. A brief description is given below, along with the problems caused for Delaware County by the lack of a County Department to run these services.

1. *Vital statistics and communicable disease control:* Under the present system, we have little reliable data on the incidence of communicable disease or of chronic diseases, accidents or environmental hazards. There are many points at which the current reporting system falls down. This is not a reflection on either doctors or health officers, but on an incredibly complicated reporting system, which could be corrected by a County Department.

a. Morbidity statistics, including communicable diseases, are reported by doctors to the municipal health officers, a time-consuming task since a doctor's patients come from many municipalities, and their postal addresses often confuse, rather than help, in determining their residences.

b. The municipal health officer sends a weekly report to the state office in Chester. The statistics are then forwarded to Harrisburg for analysis. Eventually, they are returned to the municipal health officer, *by which time any epidemic on which he would act might well be over.*

c. A breakdown in reporting from a few municipalities could create a great distortion in the prevalance of any disease—and *many municipalities do not file annual reports of communicable disease with the state.*

This breakdown in comunicable disease reporting is potentially quite dangerous. Already, Delaware County is lagging behind more progressive counties in communicable disease control. For example, in 1960, Delaware County experienced 12 cases of meningitis, more than twice the rate of the state as a whole. Also, there were over 500 cases of measles reported during 1966. Since 14 municipal health boards filed no annual communicable disease report, health boards filed no annual communicable disease report, the actual incidence of measles may have been much higher. In those parts of the nation where strong public health leadership exists, this disease is close to extinction. In addition, there is a soaring V.D. rate among Delaware County teenagers—the rate is three times greater than the neighboring counties and almost twice the state average.

2. *Chronic illness control:* Other than the county's operation of Fair Acres, the field of chronic disease prevention and control is virtually unserved by the official health agencies.

The volunteer agencies are active only on certain aspects of the problem and could be far more effective with the aid which would be provided by a professional health department. Since chronic illness represents the major community health problem, this lack of any overall official program is a serious gap in health services. In 1966, the mortality rate for breast and lung cancer in Delaware County exceeded the state average. This is highly significant as education and early detection can effectively control both of these types of malignancies.

3. *Environmental health services:* Virtually all of the roughly 100 personnel employed by municipal boards of health function primarily as sanitation or plumbing inspectors. This aspect of environmental sanitation, therefore, is often carried out with diligence, though standards vary widely. There is some question, too, whether an untrained officer can bring to this job the needed range of knowledge about solutions to the sanitation problems that he finds. Without such knowledge, the official may have no choice other than to ignore the problem or fine the owner, neither alternative being good public health practice.

Also, it is almost impossible to ascertain the thoroughness of their inspections. Municipalities are not required to report the results of food sanitation inspections to the state. They need only state how many establishments they inspect, and how often. Almost none take the initiative to report more than the barest outline of activity to the public.

Other aspects of environmental sanitation, such as clean water, clean air, and radiation programs are almost nonexistent under the current setup.

While state law mandates municipal action in sewage disposal, many municipalities in the county have failed to even appoint a responsible official. Recent surveys by the Citizens Council in Delaware County have revealed widespread pollution in the county's four small watersheds, even though none of the streams is more than a dozen miles long. The county's streams generally flow along the boundaries of numerous boroughs and townships. This makes it impossible for even conscientious municipal health officials to control pollution.

In Delaware County, there is no overall local air pollution control service. With the increased popluation of the county, the problem of air pollution is of great significance.

In 1965, a study of air pollution in Delaware Valley by the Drexel Institute of Technology estimated that nearly 2,500 tons of pollutants a day were being emitted in Delaware County alone. Of that, more than one-third was due to pollutants from transportation sources. This averages out to nearly eight and a half pounds of air pollutant per person per day. *This is nearly twice that of Philadelphia County per person.*

Another problem is that people have the mistaken notion that air pollution occurs only when it is associated with odor. There should be available a local service which is constantly at work protecting the public against potential air pollution hazards and cooperating with surrounding counties on these problems.

There is no countywide program of radiation protection despite the fact that over 300 county users of radiation producing machines or material have registered with the State Department of Health. Continuous monitoring and enforcement is necessary to protect the public against the potential hazards of radiation.

4. *Maternal and child health services:* No programs in maternal and child health are sponsored by local municipalities. A limited program of the State Department of Health is

available to a relatively small portion of the county's mothers. In a 1966 State Report on natality and mortality statistics, the poorer communities in Delaware County exceeded the state average in every category of maternal and infant death rates including natal, infant, and neonatal and in the percentage of immature live births. Immature births—those under 5 pounds—are usually premature. One of the major reasons for premature births is the lack of prenatal care. According to the State's data, the children in our poor neighborhoods fare little better if they survive birth and the first few months of infancy; while the state average mortality rate for "certain disease of early infants" is 24.1, the rate among Delaware County's poor is 52.8.

5. *Health education:* Presently, only a handful of county municipalities regularly inform their residents on health matters, and there is little educational use made of annual reports. Health education is largely in the province of voluntary agencies, acting independently.

Most municipalities, for example, do not have organized programs for the control and prevention of accidents. The State health department has provided limited programs in Delaware County, but these have had little community impact. There is no local agency responsible for poison control.

Health education in Pennsylvania schools has improved during the past decade. However, in the absence of vigorous public health leadership, the necessary parent and community involvement remains very limited. This is indicated by the failure of school advisory health councils, permitted under a 1962 law, to catch hold in Delaware County.

6. *Laboratory services:* Almost all Delaware County municipalities contract separately and privately for the bulk of these services. This results in a less well coordinated and efficient public health program.

7. *Planning:* Public health planning on a county level is now almost nonexistent. The situation will not change until public health programs are administered by qualified, full time professionals. In short, the situation will not change until Delaware County has a county health department.

The Wee-Care Babysitting Service

Ida E. Floyd, Kathryn Dunbar, and
Dorothy S. Federman

This project proposal describes our major focus of the summer—the establishment of a free babysitting service in Mantua. However, two areas deserve emphasis.

1. *Purposes:* a. Parents in the community have a great need for babysitting services at low cost or free. The incentive to seek jobs and maintain them, keep appointments, go to the hospital, or take courses, is often killed because of the difficulty of affording babysitting services. This service will provide mobility for parents as well as the security that their children are taken care of in their absence. No such service exists now; all child care programs charge about $2.50 per child per day and impose restrictions regarding DPA status, income, age, etc.

b. It is proposed that the service grow to provide health services: (1) For the children in the nature of examinations, immunizations, etc. (2) For the parents in the nature of publicity concerning family planning services, or programs involving such topics as nutrition or consumer fraud.

c. If the service is funded, jobs will have been created for community members.

d. An essential objective is to provide a broad program for preschool children.

2. *Questions to face and problems to solve:* a. *Question of* legitimate use of this service. What did we consider good reasons for using the service, who was to judge (if anyone should), how to deal with the individual who had no other commitment and would not offer time helping to babysit, how do you deal with parents whom we know could afford to pay a babysitter.

b. *Question* of whether to penalize the child because the parent took advantage of the service.

Decision: We decided to deal with the parents on a case-by-case basis, personally interviewing each parent, seeking an honest answer as to why they used the service, explaining the reasons for having established the service, requesting help if they could give any, etc. No major conflicts have risen so far; we have limited the age to 5 years old or younger, have requested donations, have urged parents to send lunch, beverage, and a sheet if they can, and we have been able to recognize extenuating circumstances without causing resentment among other parents.

c. *Question* of survival potential on a volunteer basis. About a dozen mothers have given some time this summer, some more consistently than others. What seems to be essential, given that the interest in helping is already present, is frequent communication with all volunteers before and after they work. The success of a volunteer organization rests in the mutual sense of responsibility felt by all workers. This can only be conveyed through personal contact and a genuine invitation that all workers participate in policy decisions regarding the service. The volunteers are also aware of the constant efforts being made to become funded in order to make the transition to a paid staff.

d. *Question* of black or white source of funding. Funding is the major hurdle; attached to the Proposal is a list of contacts made and possibilities still unexplored.

e. *Question* of any funds leading to the hiring of community people. This is the stipulation we decided must be made in accepting any funds—that the community people involved in the service make decisions regarding hiring.

f. *Question* of charging a fee. This decision is being worked out now with the desire being to maintain a free service, perhaps encouraging steady cash donations as parents see fit.

g. *Question* of organizational structure, working within an existing community organization with ongoing policies and programs.

Project Proposal

Title.—Wee-Care Babysitting Service.

Brief description.—Free, daily babysitting for children 5 years old or younger. Hours of operation: 8 a.m. to 3:30 p.m. Proposed hours: 8 a.m. to 6 p.m.

Geographical area.—West Mantua (1) Boundaries for publicity on door-to-door basis: 42d Street to 38th Street and Haverford Avenue to Ogden Street. (2) Newspaper publicity: citywide. (3) Boundaries of use: 56th Street to 32d Street and Spring Garden Street to Ogden Street.

The project grew out of prolonged discussion and personal contact throughout the neighborhood, including door-to-door contact, discussion with businessmen, politicians, police, school coordinators, etc.

Purpose.—a. To provide free babysitting to enable parents to seek and maintain jobs, take courses, go to the hospital, keep appointments, enter training programs, etc., to provide mobility for parents and the security of knowing that their children are cared for.

b. To provide health services (1) for the children i.e. immunizations, eye and ear testing, and (2) for the parents, i.e. family planning services publicity, programs of an educational nature on such topics as consumer fraud, nutrition, rat control.

c. To create jobs for community members.

d. To provide a broad program for preschool children, i.e. group activity, arts and crafts, trips, films, music. Many existing programs do not accept the child younger than three years old, or they require $2.50 per child per day, or they make some restriction regarding income, DPA status, employment status, etc.

What has transpired since July 1st.—I. Prior to Opening on July 15th:

a. Obtained rent-free facilities at Haverford Center, Lutheran Social Mission Society at 39th and Wallace Streets. Room is furnished with small tables and chairs, refrigerator, toys, etc.

b. Publicized for a meeting to arrange schedule of volunteers.

c. Planned painting party with the teenagers and cake and hot dog sale to raise funds and publicize Opening.

d. Solicited for donations for babysitting service and the sale. Response was uniformly generous from the community, businessmen, police, suburbs, Board of Education.

II. Operating of the Service:

a. Publicity.

b. Ironing out of details (1) programs and routine, (2) registration forms, (3) meals. Parents are asked to supply lunch and sheet.

III. Present focus:

a. To stabilize service on volunteer basis.

b. To seek funds (see attached list of possibilities).

Problems encountered.—a. Regulations of the Department of Welfare which may be impossible to comply with in present facilities.

b. Volunteer nature of workers, difficulty of ensuring stability of schedule.

c. Question of legitimate use of the Service; demand of some reciprocity on the part of the parents.

d. Question of charging a fee to ensure some income for the Service. Possibility of asking for regular donations.

e. Situation in which an independent service is set up within another community organization with ongoing program and policies.

Possible Budget.—Staffing: 1. One individual engaged in planning programs for children.

2. One individual responsible for schedules and contact with volunteers.

3. One individual coordinating health-related aspects as stated above.

4. One individual to overview; ie. maintenance, finances, responsibility for registration, correspondence, etc. Estimated salaries: $7,000 to $10,000. Maintenance $2,000.

Space.—Haverford Center all year round; if expansion seems necessary, possibilities lie with the Department of Recreation, Friends Social Order Committee, Mantua Community Planners.

Equipment.—Already obtained but in fair condition: cots, cribs, small tables and chairs, toys. Toilet and sink and play yard adjoin main room.

Needs.—First aid supplies, disposable diapers, bathinette, record player, toys, etc.

Estimate of funds required if starting from scratch: (not including salaries) $6,500 to $7000.

Contact re: Funding.—1. Black Coalition;

2. Philadelphia Coordinated Community Services;

3. MIC (Maternal and Infant Care Program);

4. Episcopal Diocese;

5. Friends Social Order Committee;

6. Redevelopment Authority;

7. Model Cities;

8. Department of Recreation;

9. RMP (Regional Medical Program);

10. Smith, Kline, and French, Merck, Sharp and Dome;

11. Philadelphia Foundation;

12. Department of Welfare.

Unexplored possibilities.—1. Presbyterian Hospital;

2. Lancaster Avenue Businessmen's Association;

3. PAAC;

4. West Philadelphia Mental Health Consortium;

5. Public Health Service Research grants.

The Photography Club at St. Christopher's

Richard Raggé and Richard Baines Morrison

Education of community children is an important concern of the Comprehensive Group Health Services (CGHS). They felt the establishment of a camera club would serve to educate as well as to occupy a number of children during the summer. This is what was presented at orientation as a possibility for a project.

The first 2 weeks consisted of obtaining facilities, financing, equipment, a list of potential club members, and advice from people working in programs of this type.

Facilities consisted of a converted eye examination room from the health center as a temporary residence for the darkroom of the club.

Financial support came from the SHO photography allotment and from donations from one foundation, Food Fair Stores and 14 area stores.

The city's Department of Recreation has a program called PIX which helps to supply photo clubs with film and cameras. We could not use this because (1) we were too late in applying, and (2) they were dealing generally with a different age group (13-19) and most of our club members were between 10-14; but I feel if they were approached early enough, something could be worked out.

A list of children (ages 10-15 years) was gathered from the personnel of the health center. Some were recommended for special reasons such as difficulty in school. Approximately 20 children were in the club's summer portion.

The club has offered a good opportunity to get to know the community, especially some of the children from it; and to work with these children to make ourselves more aware of some of the problems that exist in a poor community.

Two projects for the children evolved, one in conjunction with the social services at CGHS. For this service the Camera and Youth Studio (C&YS) has in three cases supplied pictures of specific housing problems they were dealing with. The other project was supplying the Hartranft Corporation with pictures of various lots in the community which were in bad condition, also pictures of the community crews that were cleaning them up. We are also supplying several groups with sets of pictures of conditions in the Hartranft area. It has been the opinion of several of the community leaders we have met that many people in the community do not realize the extent or the degree of the problems some people face.

These projects are only a few of the things we have done as a club during the summer. We are now making arrangements to continue the club on a year-round basis.

One of the biggest hangups with "the establishment" was a contact with a local Business Association. Speaking with the past president of the association about support for the photography club, we found that the association has a means of handling such requests for support. Community people would have to save sales slips from participating stores and then turn them in to the association. The people would then receive 2 percent of the total as the contribution. She said that almost no one had availed himself of the plan. In our opinion, the plan has worked well in keeping the community from receiving anything, yet the Business Association can say that they tried.

To end on a positive note, our relationship with the CGHS has been a friendly and cooperative one. The relationship it has with the community is a very good one which would make the center a good place to educate medical students on community relations.

SOME OTHER INTERESTING EXPERIENCES

Karen Lynch

A few of the papers written about the summer's experiences stand alone. These are grouped for convenience.

The views of the Hawthorne experience are presented. Each highlights a different aspect of the program and the difficulties encountered during the summer. The reports, however, point out the importance of SHO's cooperation staffing by students and local people in Hawthorne.

The other articles in this section describe a wide range of activity. Project workers at Pernet Family Health Service, Houston Community Corporation dealt with significant issues for their communities. The two project workers at Holmesburg Prison report a totally different experience.

Each of these articles should be read individually for each presents still another viewpoint on the summer's experience.

Hawthorne Viewed by a Staff Member, a Student and a Community Worker

Charles Floyd, Staff: The SHO personnel assigned to this particular site have been with us now approximately four weeks as of this writing. The problems we have encountered thus far have been minimal and I feel we have solved them to each person's satisfaction. However, of these problems, I feel the greatest has been lack of proper orientation of the students, prior to their commitment. I recognize that this was done on purpose to some extent, but I personally feel it was, perhaps, too general in scope and too fragmented. I think that in order for an orientation to be beneficial to the students, it must be specific as to the particular site. I also feel that if this job is handled prior to the commitment, it can alleviate other related problems, e.g. what to work with, where to work, etc.

An example of the above problem as it relates to this particular site is as follows:

SHO personnel assigned here (Miss Oster, Mr. Sesso and Mr. Williams), were handicapped, so to speak, due to lack of proper orientation. Although Mr. Sesso is from the adjacent neighborhood, it was nevertheless, a problematic situation. They were not given proper information as to the age group they would work with, where the base of operation would be, and the resources they would have at their disposal. Some may feel that this is the responsibility of the preceptors who are actually in the programs and the community. However, regardless of where the responsibility should fall, I feel the timing of this is more important. Whether it is done by SHO or the preceptors, to me, is beside the point. The point, as I see it, is to help the students to be aware of the community they will serve, and the mechanics involved in the serving. Now if it is decided this is really a job that belongs in the realm of the preceptors' responsibility, it nevertheless should be executed before the students are assigned and employed in the community. Failure to do so will only add to their frustrating situation and it could stifle the creativity and imagination they bring as part of their offering services.

In this particular site, the focus for the SHO personnel has been recreation in the Hawthorne Area. Utilizing such activities on a group basis such as bus excursions to distant points (Atlantic City; Hershey, Pa.; Dorney Park; etc.), picnics, Phillies games, etc., afford the students the opportunities of beginning a working relationship with the teens. Once this relationship is formed, they are then able to get into the more personal and often specific problems which can be worked upon on an individual, but more ideally, on a group basis. Most important in this program, originated by United Neighbors Association is the tie it has to the Jefferson Hospital Children and Youth Services. Referrals are made here for teen problems.

The relationship of this program to non-health agencies has been most encouraging. Collaborating with the PAAC (Philadelphia Anti-Poverty Action Committees) they were able to work out bussing schedules for trips or excursions. The same is true with the Board of Education and their Operation "Green Grass." Arrangements were made with the staff at the Children and Youth Center to have physicals performed. Work was also done with the Housing Authority as they were made aware of certain hazards in the Housing Projects and surrounding grounds. The latter was an outgrowth of a survey done by the SHO personnel.

Don Sesso, student: Much of our first week was devoted to becoming oriented and acquainted with community people and services. This first week was challenging in that we were "wetting our feet." I was somewhat disappointed by the lack of a pivot point or "structure" upon which we could begin to develop our projects. Most of our activities hinged upon the opening of the Hawthorne Annex, which I felt took too long to open anyway. We couldn't do many tangible things during the first week. As a result, I felt that perhaps I was possibly remiss in my efforts. In fact, I didn't declare the compensation which I was to receive for an extra day's work, prior to my arrival at Hawthorne.

During the first week, we arranged a meeting with the teens. Fifty guys and girls participated. Many valuable ideas and suggestions were given by the teens. The kids were a bit leery or cautious; after all, we are white strangers. Fortunately, we had Nate as a co-worker. Nate commanded the respect of the teens; "Nate is cool," and so a rapport with the community began.

During the next weeks, we attended staff and community meetings. It is a sad commentary, but we went to many sessions and only a few of them were significant, in my opinion.

As our first outing we planned a trip to the Phillies game. We considered this a moderate success, but since we had to get there on our own by public transportation, no girls came.

It was at the end of the second week that the *Deux ex machina* appeared in the form of excursions sponsored by PAAC. This generated much interest and enthusiasm from everyone, and it served as a focal point for our future activities. We went into the community to meet and recruit the kids. According to our community worker, this went over big, because it showed we were interested in associating with everyone. The trips provided us with the opportunity to talk seriously about health, education, or social concerns. We are hoping that these opportunities will increase in number during the future weeks. Rapport takes time, especially since we were dealing with such a large number of people, many (most) of whom "go and come" from day to day. I must mention the relationship that we've developed with our "captain," Tom Bradley. He is a great guy who sets an example for his friends.

Much of our time in the passing weeks was spent in writing to, or contacting, people associated with recreation or things which would interest the community. We helped to staff the Annex, and also aided in setting-up "Tot Lot". Tot Lot started nicely, but seems to have waned. I also became interested in recruiting youth and helping Jim Washington coach a track team. Results are OK so far, but the verbal affirmations and support greatly outweighed the actual number of teens who participated. However, this is understandable; it's pretty tough to run in 95 degree heat.

Also in the past few weeks I've become a friend with a group of about 10 boys, who are 12 and 13 years old. They had been uninterested in day camp, and I guess felt young for our PAAC excursions. They are nice guys, docile and willing to learn. We've gone on trips which were planned to be both educational and fun. I knew I would encounter difficulty getting them to leave their boats at the Schuylkill River, but was I amazed when I had to "drag" four boys from the Logan Library. We also went to New York, visited science centers, and medical school labs.

Our efforts during the remainder of the summer will be to continue at the Hawthorne Annex; to contact local business and perhaps news media in reference to assistance; to set up a film series.

In answer to the research question of, "What is your central problem?" I can make suppositions. I must first state that my analysis is meant to be constructive, and I hope it will be construed as such.

A. How important was it to have *health science students* since the teens are predominately interested in recreation? There was a group, however, interested in more than recreation and we are trying new ways to arouse the interest in the others who are the majority.

B. There are times when I question the necessity of three of us as staff on a permanent basis. Definitely *all three* were needed at various occasions for the proper relationships to occur.

The answer to this dilemma might come about if there were much educational interest from the teens, but we were there to help instill this in the first place. In addition there must be added financial support for equipment and materials to implement any program we attempt.

Another answer might be a surge of increased creativity on my part; heaven know's I'm *trying*.

In conclusion, urban development programs are essential, and I hope that our contribution at Hawthorne was meaningful. We would like to express our gratitude to our preceptors for their guidance.

Nate Williams, Community Worker: I would like for the recreation and education program to continue through the fall, because I think it is a wonderful program for the children of the Hawthorne community. As for problems, I have had none except for when we went to Atlantic City. The PAAC staff were ignorant to the fact that we were dealing with children and not with adults.

Some of the projects we worked with are not too good. And the children are old enough to know in addition to recreation they must learn other things, like visiting more important places and doing more important work at the centers. In that way it would be much easier for the ones that are there to help them. I enjoyed working with the children and maybe next summer it will be better.

Teaching Sex Education Classes at Hartranft Community Corporation

Forest Lang: There was no direction at Hartranft. The first problem was finding the right bag. The anatomy and physiology of sexuality is one of our few areas of expertise. Sexuality transcends racial and ethnic groups. Inadequate and erroneous sex education is the rule. V.D. control is among the four priorities of Hartranft health committee. V.D. and prenatal mortality are serious medical problems in the area.

Our first problem in planning was to discover the amount of sex information among area youth and their interests. A teaching plan progressing along a course envisioned through the analytical mind of the medical student would fail. We solved the problem by allowing anatomy and physiology to grow naturally out of discussion on V.D., intercourse, birth control, and birth instead of vice versa.

To research and plan a relevant course ran us face to face with institutions entrenched in out-dated mores. Building up a birth control kit for educational purposes was a real problem. Planned Parenthood decided to loan us, for one day, their birth control kit. They dispense thousands of I.U.D. and diaphragms, yet to loan one to a medical student for more than a day became a serious problem. It was only through a personal contact at the health center that we acquired these materials for the summer.

Also, the films at the Philadelphia Public Health Department were often inadequate. They were poorly described in their catalog. We had to personally screen out the moralistic and threatening movies related to sex and V.D. The "Innocent Party" is an example of such a movie. Other movies (Boy to Man) were inadequate for the white community and inappropriate for the black. Most characteristic was the attitude of the Narcotics Addiction Center. They would not lend us a film on dope addiction for fear of putting ideas in the "little minds" (our boys have been on grass for years).

The same problem occurred with films on childbirth. Jefferson Hospital would not lend us its film because the boys were too young. Hahnemann allowed its birth film out only with a physician. Childbirth Education Association has a great film. But the rental is $10 because they are a private institution.

Finally Hartranft would not financially back the necessary expenditures because they did not approve of our sex education on their facilities.

These problems exemplify the need for SHO and all future doctors to push for realistic resources in youth education.

Yvonne Butterfield: Members of the sex education classes were recruited from preexistent groups—clubs, gangs, baseball teams. We felt that in this way classes would feel more comfortable if all were already friends, that information would be more efficiently retained and passed from one to another, that attendance would be better if a leader of a group could be interested in coming himself. This recruitment tactic seemed to work well. Attendance remained a problem as gang fights, baseball games, and trips conflicted with scheduled classes. We tried to remain as flexible as possible in scheduling to allow for these occurrences. If possible, community recruitment is best. We used this whenever possible.

Classes were kept small (less than six) to encourage questions and discussion. All material was presented informally, allowing questions at any time. The length of each class varied depending upon the amount of material to be covered and class interest.

We found team teaching most effective. Forrest Lang and I felt that we could present a more honest and accurate picture of the topics together than separately. My presence may have helped the boys learn to communicate better with a woman, Forrest's helped accustom the girls to deal with male doctors more easily.

We also felt it important that we were young and not authority figures. We think that the classes found it easier to ask questions they might be reluctant to ask their teachers, clergy, parents, etc.

Good visual aids are of paramount importance. Films should be previewed beforehand since catalog descriptions can be misleading to say the least. If material presented in the film is new it must be discussed before the film is shown. Otherwise the best presented movie makes little sense. Many of the films require discussion afterwards, especially those dealing with sexual attitudes.

Clay models of the female reproductive system—simple to make—are invaluable. Conceptualizing the uterus, vagina, ovaries from drawings is practically impossible even for the medical student. Models were made to scale. A female pelvis was brought in to show how the organs were situated in the body. A model pelvis was also useful in describing childbirth.

Whenever possible examples of tampons, napkins, deodorants, and powders should be used when explaining menstruation to either boys or girls. Classes should be directly involved by allowing them to open the boxes, use the powder and sprays, take apart the napkins, place the tampons in water. This same approach is necessary when discussing birth control. We purchased examples of foams, jellies, suppositories and borrowed diaphragms, IUD's, and pills. We inserted IUD's into the clay model of the uterus to show how it is done by the doctor, squirted foams into the clay vagina. Everyone was allowed to handle everything. If possible, material was presented by question and answer to encourage class participation. This was particularly effective with birth control since classes usually had some idea of a method. The idea of "corking" the vagina to separate sperm and egg leads easily to the idea of foams and jellies. A rubber for a woman is a diaphragm.

With each subject, particularly venereal disease and birth control, classes must be told where to go for advice and treatment.

In summary, classes were encouraged to participate themselves as much as possible, by asking questions, handling materials, selecting movies, and making models.

Preparing a Community Health Booklet at Houston Community Center

Zack Pinkney, Mike Rutberg, Lynn Sullivan, and Pat Witherspoon

Our project was the writing of a community health booklet. The booklet contains articles on health services available and how to go about getting them. Included topics are: Medical Social Service; Community Information and Referral Service; finanical help through Public Assistance, Medical Assistance, health insurance—Blue Cross and Blue Shield, Medicare; Health Center District 2; Chest X-Ray Service; Venereal Disease; Help for the Alcoholic and Drug Addict; Poison Information Center; or Ambulance Service, Police Red Car, Cabulance, Wheels for Welfare; Dental Care; Community Mental Health Center; Rehabilitation Center; Planned Parenthood; Senior Citizen's Center; and a health director of area hospitals and practicing physicians, dentists, optometrists and chiropodists in the area.

We decided on writing the booklet on our own. We wanted to do something tangible so that people would be able to see that we had done something. Our work group was two health science students and two youth interns. We were responsible to our preceptor, a community organizer at Houston Community Center.

We got information for the booklet by interviewing people in the areas previously listed. We started with Public Assistance, Medical Assistance, Public Health, the Community Information and Referral Agency, and Medical Social Service. We were further referred by these people. We then wrote the articles and typed, stenciled and mimeographed the booklet ourselves at Houston Center. The cost of paper was covered by United Health Services (an agency of United Fund), and the cover's cost was paid by SHO.

We distributed the booklet ourselves going door-to-door to 1,500 households. The people's response was in the main, positive; people were glad to have a convenient source explaining what things are and how to get them. Some people accepted them passively. Others said they couldn't read.

Southern Philadelphia will hopefully have a Community Health Center Service within 5 years. Such centers act as a central point for health information and referrals as well as for health care. Booklets such as ours, written on a community format, can act as a central source of information until the centers are formed and active. It is our recommendation, therefore, that booklets be written for all areas of Philadelphia. They can be informative and convenient based on a community or geographic basis. Booklets could be sponsored by city agencies interested in health—United Health Services, Health and Welfare Council. These agencies could be approached to organize and write the booklets themselves, or perhaps health students could be employed on a part-time job basis to write them. Distribution could be handled by (political) Committeemen, working on a Ward basis.

Working With Pernet Family Health Service

Joan Gomes

I would like to begin this paper by a brief description of the Pernet Family Health Service with which I have been working this summer.

The Family Health Service is a voluntary nonprofit home health agency, staffed conjointly by the Little Sisters of the Assumption and lay personnel. Their work with the families, in either a crisis intervention situation, or with the more long-term multi-problem complex, seeks the overall aim of the agency which is the preservation of the values of family life.

The optimum level of the family's physical and emotional health is encouraged and fostered through the rendering of direct services which seek to identify and alleviate the health and social problems that threaten the family structure. These services are:

1. Skilled Nursing Care; 2. Maternal and Child Health Care; 3. Homemaker Home Health and Aid Service; 4. Referral Service; and 5. Health Promotion and Instruction.

Everyone who applies is evaluated for service. Admission criteria are necessarily limited to: acuteness of need, geographical area and availability of staff. Families are referred to the agency through numerous professional and nonprofessional sources.

The Sisters have recently opened a satellite office in Our Mother of Sorrows Social Center—where 1,100 children from the neighborhood are registered for day camp. The office has become a first aid station where the children come for minor injuries or are brought there by their counselor for more serious problems, including infected wounds, ring worms—or suspected battered child syndrome. The problem there is that many of these cases should be closely followed up but the lack of personnel does not permit them to do so at the present time. The Sisters hope to be able to penetrate the area where the center is located, an underprivileged area with a predominantly Negro populatiion. They have pledged themselves to combine their individual and group efforts with community strengths to restore families to their rightful place in society, and to do something about the conditions which create poverty.

A problem I have noted in working with the Sisters is the geriatric patient. Many times referrals are made for elderly patients who require custodial care in their home. The aging person is surrounded with loss: loss of spouse, family, health, independence, mental capacity, This sense of loss is a profound human experience. It causes an awareness of isolation, of not belonging, of uselessness. In trying to respond to their needs the Sisters have burdened themselves with a heavy case load of geriatric patients. It seems to me that they should concentrate their efforts in working with families, especially with multiproblem families, where the underlying cause of their problems could be explored in an intimate in-depth family contact.

I have discussed this problem with the Sisters who were aware of it and have tried to discharge some geriatric patients in order to be free to work with families but it is very difficult as the community has no provision for the patient who requires custodial care. I also believe it is important for the Sisters to limit the dimension of the area of service to West Philadelphia; otherwise too much time is spent travelling.

In my interpersonal relationship with the Sisters and other people involved with the agency there was good communication with coworkers as well as with the patients I have tried to help. The only problem encountered in my work was my professional limitation. Being only a student, my assignment had to be limited to patients who did not require professional skilled nursing. But, by penerating the homes of several patients, I feel that I have had a unique experience and an occasion to observe many problems that poverty creates and that create poverty.

Holmesburg Prison Project

Lawrence Kron, Alan Cohler, and
N. Joblon, M.D., Preceptor

We have been involved this summer with the State Maximum Security Forensic Diagnostic Hospital at Holmesburg Prison. This hospital deals primarily with court committed offenders. The hospital serves to give a complete Psychiatric Evaluation of its inmates, which is subsequently reported to the court. Our function at this institution is that of Mental Health Workers. In this capacity, we deal with the compiling of social history and character evaluations of the patients. In addition, we have been involved in numerous Fact Finding research projects concerned with both followup and therapeutic studies.

Since the hospital deals with an incarcerated population there is little room for flexibility, i.e., the regimented structure is necessary for functional utility. It is this highly organized environment that we found ourselves in, and within which we must function effectively and educationally. It is apparent that our primary problem was learning to deal with the strictness of the environment.

There is no typical character type here, but a general appraisal of the people we work with is in order. The majority of these patients are poor, deprived, and considerably socially disturbed. They are the products of broken homes, little education, and even less motivation. The main problem in our dealing with these men has been the difficulty in establishing interpersonal communications of a meaningful nature.

We presented ourselves to the patients as both confidant and therapist. Therefore, together with the administrative and psychiatric staff, we endeavored to provide the courts with concrete detailed information, as well as beginning therapeutic and motivational programing.

In summary, the vastness of the problems which give rise to the personalities we have seen is incalculable. Therefore we have striven to work within the structure of this institution to provide a service to both the prevailing judicial system and, in a limited capacity, the inmates and their families. Obviously, there are sufficient problems to deal with for a long time. We, therefore, feel this to be a continuing functional project for the Student Health Organization. Both the insight one derives from this experience, and the opportunity to be productive, more than justify this project's existence.

Drama as a Means of Changing Health Professionals' Attitudes

Lucia Siegel

I came to my experience with the Student Health Organization having a fairly well conceived idea of the kind of project in which I wanted to work. Coming from graduate school of Social Work and having spent several summers working with residents of the ghetto in various capacities, I recently have made a decision to devote an increasing amount of my time to understanding and exploring what I consider the white economic and political power structure, responsible for the major decisionmaking in this country. It is only through influencing this power structure by many methods—"educational" efforts, protest movements, and mass civil disobedience, etc.—that individuals can work for creative change. And the issues that are best suited as rallying points for initiating change are those which affect the individuals personally. Nothing is more personal to an individual than what happens to him as a result of the type of lifework he chooses. One's daily work experience is probably the most profound molding influence that is allowed to operate on an individual's psyche. Therefore, in "The Disaster Drill," a short, one act play, I wished to not only introduce people to and impress them with the gross inadequacies of the existing health-care delivery system, but to confront health professionals with a situation that they themselves might be in someday, and to depict characters that could very well be themselves. My primary aim is to make health professionals begin to question their educational experience, their work environment, their attitudes toward those they treat, and their feelings about the very type of life they are leading.

Of all the groups to whom I would like to present the play, medical, dental, and nursing students, and beginning students, are first on my list. These young people must be forced to question their most basic assumptions and ambitions, as well as to see as lucidly as possible the huge problems now existing in the health care system. In addition, I definitely do see possibilities for presenting it to any group which is either directly medically oriented or peripherally related.

The best chances for the play being widely circulated would come from the Student Health Organization's sponsorship of it as a packaged program, the play being followed by small discussion groups led by people trained in "sensitivity" techniques. A permanent cast is yet to be assembled and the possibilities of obtaining a director have not yet been explored. The play shall have its first rehearsed reading on August 28, 1968, at the Philadelphia Student Health Organization's final conference.

Misericordia Hospital

At the beginning of the summer of 1968, representatives of the Philadelphia Student Health Organizations and Misericordia Hospital Division of the Mercy Catholic Medical Center discussed the desirability and feasibility of developing and carrying out a 10-week program designed to expose health science students to the patient as a social being. It was proposed that, the health science student who may eventually serve lower class patients lacked an understanding of the problems that beset them. It was also proposed that patients of the lower class (ghetto) usually do not receive health services commensurate with their needs. After weighing the pros and cons and with the consent of the hospital administrator and medical director the program was begun.

Purpose of the Program

The purposes of the program were as follows:

1. To make known to the community the health service programs offered by the hospital.
2. To reduce the gap of communications and understanding between community people and hospital staff.
3. To pin-point problem areas and make recommendations for their resolution.
4. To demonstrate how health services may be improved and made more available to the entire community.
5. And finally, to give the health science student the opportunity to develop an awareness of the problems of those individuals living in a lower class area.

Structural Design

The program was composed of the following components:

1. A cervical cancer detection phase;
2. A recruitment phase for the hospital's Neighborhood Health Center;
3. An emergency room out-patient department survey phase;
4. A cultural enrichment phase for neighborhood children (Operation Create).

Personnel

The program was carried out by the following individuals:

1. Three health science students;
2. Three community health aides;
3. One art education major (teacher); and
4. Two Sisters of Mercy of the teaching vocation.

Preceptorship

In order to develop a smoothly operated program and to handle problems as they arose, the aides were assigned to preceptors who met with them periodically.

The Cervical Cancer Detection Phase

Operating with a grant from the cancer control division of the Department of Health, Education, and Welfare of the Federal Government and under the direction of Dr. J. Edward Lynch, the director of the Department of Obstetrics and Gynecology, the hospital established a cervical cancer detection program for women, which is designed to detect cancer of the cervix in its earliest stages.

Past efforts to recruit and involve lower class community people in programs designed to make available and improve the health care services they receive revealed that this particular segment of the community did not respond readily to traditional methods of communication, i.e. the news media. Therefore, it was decided that new methods of recruitment should be developed for the Pap smear program.

Approaches and Results

The community health aides decided that the best way to augment the recruitment effort was through direct and personal contact and established the following objectives:

1. To recruit women who had not had a Pap smear test within the past 6 months.
2. To inform all women in the area serviced by the hospital of the existence and availability of the test.

The program was initiated by conducting interviews with the mothers of children who were selected to attend the cultural enrichment program Operation Create (see section below).

Having completed the initial interview, the interviewer discussed the Pap smear test with the child's mother; due to the rapport established through the interview pertaining to the child, the reception to the idea of the Pap smear test was favorable. Moreover, through this contact the interviewer was able to get referrals of families, friends and neighbors in the area.

The use of a familiar name for introductory purposes increased the possibility of favorable reception. The interviewers continued using these secondary referrals until they were finally scheduled for appointments or "disposed of" (i.e. some referrals were outside of the hospital's service area and therefore referred to closer places for treatment).

Extending the concept of direct contact, the interviewers canvassed door-to-door and conducted interviews in the hospital's clinics. Because of the high percentage of working women in the area, contact was made with about only one-fourth of the women in the blocks canvassed.

The door-to-door technique provided very interesting insight as to the attitudes of some of the neighborhood residents. The following statements were taken from reports submitted by the interviewers:

"A few women, mostly elderly, would not listen at all. Others listened but were totally disinterested. Some reacted with a negative attitude and a fear of cancer. 'If I have cancer, I don't want to know it' was one of the comments recorded.

"Most of the superstition and misconception about cervical cancer was deeply entrenched. This convinced us of the need and importance of a program such as this. An attitude held by a woman on the 5300 block of Larchwood Avenue, concerned her seeming immunity, because she was white and middle class. This lady said that neither she nor the other women on that street would be interested, and that what we really wanted were the 'black streets.' "

The door-to-door contacts were effective but they consumed a great deal of the interviewers' time; therefore, efforts were concentrated on working through community organizations and churches.

Almost immediately the community health aides discovered that the vast majority of the community organizations in the West Philadelphia-Misericordia Hospital area were disorganized, that they existed only on paper and in name, and had registers of nonparticipating members. However, those organizations that were contacted promised to publicize the cancer detection program.

Moving on to the area churches, the aides were able to get several priests and ministers to announce the existence of the program during church services, in fact, at one Roman Catholic Church the aides, with the assistance of a church group, solicited registrants for the test at the end of each Mass on a given Sunday.

While most of the clergymen were cooperative the aides recorded the following incidences which are worth relating:

"At (blank) church we were told by the secretary that their members were not the type we were looking for. First she said, that her congregation was too old, and when this was answered by the fact that cervical cancer has a higher incidence among older women and that this indeed would be a substantially beneficial program for these women, the secretary abruptly said that most of their women were from the suburbs and that she would not see us.

"In another incident Reverend (blank) of (blank) Baptist Church, who is an elderly cleric, said he would be embarrassed to make the announcement. He did refer us to a woman who was very active in the parish activities and who handled our program as well as could be expected."

Avoiding the impulse to hurry the ten-week period of operation to a close, the aides, through cerebral gymnastics, decided to recruit block chairmen and to encourage them to solicit their block members. They reported the following:

"Astonishing returns resulted. For example, in one block, 45 women responded and have made appointments for Pap smears. The reasons are that these block chairmen know when to contact their neighbors and they do not run into the obstacle of suspicion. We fully educated these women to our program and answered any of their questions so that they, in turn, could act as health educators to the rest of the block. It must be emphasized that these block chairmen must be fully educated and understand their task so that they may not only carry out their tasks and convince the women in their block to take preventive measures against cervical cancer, but to guard against any misrepresentation and perpetuation of misinformation."

The aides found out as a result of following up unkept appointments, that people were often scheduled for appointments without a realistic assessment of the time factor. For example, some were scheduled for appointments only a day or two after they received their announcements and after they had already made other commitments. In addition, some received their appointment cards 4 or 5 days after they had been scheduled (via Pony Express).

Recommendations

1. That appointment be confirmed by telephone call before assuming that the woman

has received information about the appointment.

2. That the postcards be sent out after confirming the appointment and about a week in advance of the appointment time.

3. That consideration be taken of the patient, i.e. certain arrangements may have to be made in order to keep an appointment, i.e. babysitter, transportation, etc.

4. That the backlog of women which were recruited be scheduled for appointments as early as possible, even if it would entail an extra day a week for appointments.

5. That a community health aide be hired. This health aide, as a member of the indigenous area, be assigned certain tasks. Among them:

(1) Continue the program which has already proved successful.

(2) Since the regular secretary cannot make evening calls to schedule the women for evening clinics, the community health aide would assume the task. Considering the fact that there are many women in this area that work during the day (as has been proven by canvassing and mentioned earlier in this report), the evening service is essential.

(3) Consider that this health aide may indeed be an essential feature of instituting a program of preventive medicine in this community with its base at Misericordia Hospital.

Recruitment for the Hospital's Neighborhood Health Center

The site of the Neighborhood Clinic (52d and Thompson Streets, some 2 miles from the hospital) was chosen because no hospital actually serves the area and because hospital records showed that a relatively small number of patients from this area had seen a doctor prior to admission. Since the majority of cases from this area were maternity patients, the pilot program, under the department of obstretrics/gynecology, offered prenatal and gynecological care and free cervical cancer detection tests.

Working closely with the West Area Health and Welfare Council, the Public Relations Department discovered that merely establishing a clinic in a given community does not guarantee its acceptance, no matter what services are offered or for how little. Therefore, it was decided to invite the chairmen and leaders of various community organizations in the immediate area of the clinic to a dinner at the hospital for the purpose of seeking their advice and ideas.

The director of the council, furnished a list of the neighborhood organizations for the invitation list. Also, invited were: chairman of the West Philadelphia Chamber of Commerce, representatives of the American Cancer Society, head of the local school district, and the area representative of PAAC. Representing Misericordia were: Misericordia Hospital's administrator, director of the clinic, director of the social service department and the director of the public relations department.

Approaches and Results

In spite of a logical and sequential approach to establishing and publicizing the clinic, returns from client appointment files were not favorable.

As mentioned above, it became obvious to the Health Aides that the community (for which the clinic was established) did not respond to traditional methods of communication, i.e., the mass media. Therefore, the following objectives were established:

1. To visit meetings of community organizations for the purpose of explaining the function of the clinic.

2. To make door-to-door contacts in order to explain how community women could use the clinic.

The health aides made numerous visits to Community meetings and churches. They noticed that those in attendance represented a segment of the community which was articulate and knowledgeable of existing health care services. Moreover, this particular group of people maintained very little contact with the "grass roots" people and had personal physicians at hospitals other than Misericordia (primarily Mercy Douglas Hospital).

During the month of July 1968, the health aides made door-to-door recruitment contacts. According to Mr. James McGee, director of the out-patient department, the clinic served the greatest number of patients for any given month since its opening (see July statistics below).

As a result of the door-to-door contacts, the health aides discovered that the "community" was not aware of the existence of the clinic and its purpose. In addition, racial and religious misconceptions were evident. "Most of the black people that I contacted felt that the clinic was for Catholics only and they thought that you had to be white to receive service. Most of the whites living in the area were Italian and they thought the clinic was for blacks and that it was degrading for them to go there" was the comment of one health aide.

Neighborhood Clinic, July 1968 Statistics

	Number persons
I. Health services rendered:	
Gynecology	14
Pap Smear	16
Pediatrics	4
Prenatal	5
	39
II. Information contacts:	
By telephone	21
In person	12
	33
Total I and II	72

Recommendations

In an effort to increase the utilization of the clinic, the health aides recommended the following:

1. That a black and a white receptionist be on duty on alternate days.

2. That a full-time health aide be hired to promote the clinic and other hospital projects.

Emergency Room-Out Patient Department Survey

The Emergency Room Out-Patient Department represents the point at which most community people have their first contact with the hospital. In instances where there are racial and cultural differences, the community person often gets a negative impression of hospital's staff and its policy; racial prejudice and bigotry are often claimed.

If a hospital is to serve effectively the community in which it is located, there must be a reasonable amount of mutual understanding and tolerance of differences by both the patient and hospital staff.

In an effort to pin-point problem areas and to recommend changes directed toward improving hospital-community relations, a health science student was assigned to the department.

Approach and Observations

The health science student first oriented himself (through consultation with staff) to the function and operation of the E.R. after which he attempted to define existing problems and to relate them to the developing concept of hospital-community relations. The orientation included direct observation of the E.R.'s personnel and procedures as well as interviewing patients to determine their general background, i.e. economic status and health service orientation.

Of the two hundred (200) respondents interviewed, the following percentages were calculate:*

(A) 80 percent were employed, 7 percent retired, 8 percent on public assistance, 2 percent on social security benefits related to the death of husbands, and 3 percent received their support from the divorce courts.

(B) 60 percent had family physicians, 23 percent relied on Misericordia Hospital for health care, 5 percent relied on Philadelphia General Hospital and Hospital of the University of Pennsylvania, the remaining 12 percent represented Mercy Douglass Hospital, St. Christopher's Hospital, Police Welfare clinics and union clinics.

(C) 2 percent had periodic physical examination every 6 months, 29 percent every year, 12 percent every 2 years, and the remainder (57 percent) only when they were ill.

(D) Less than 5 percent had chronic illness in their family.

(E) 56 percent of the patients had never used the clinics at Misericordia, while the remaining 44 percent had used the clinics once or more.

The student observed the following situations and occurrences which are submitted as possible areas of concern as they may affect patient and hospital staff relationships:

First, situations which usually created conflict between the patient and hospital staff were those in which that patient felt that he suffered from a fatal disease or a grave physical injury. As a result of either case the patient was emotionally upset. To him, his condition appeared critical and immediate attention was required. To compound the situation he may have been accompanied by members of his family or friends who were also emotionally involved.

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* (Notice is here given to the fact that this survey is skewed and therefore valid only insofar as it helped the Health Science student to get some very general insight into the background of the E. R. patient).

In addition, this situation in the E.R. is often compounded by the fact that the hospital is known throughout the community as a "white Catholic hospital". Consequently, the Negro patient becomes concerned about the possibility of discrimination against him because he doesn't trust this alien environment (credibility gap).

Secondly, as is the case in E.R.'s in general, patients are treated on the basis of the seriousness of their conditions and often those who are less ill are required to wait several hours. The priority of service was often interpreted by the black patient as being discriminatory. Also, "conflict occurred when patient sought emergency treatment for a nonemergency problem. As a result of having to wait while patients who needed immediate care were served, the black patient seemingly felt that he was being discriminated against."

Next, "situations which did not produce immediate conflict, but which were not conducive to good rapport between the hospital staff and community people developed when the doctor was unable to communicate with the patient because of a lack of command of the English language to say nothing of the vernacular of the black patient."

In addition, the problems involved in improving hospital-community relations are greatly increased as the result of long waiting periods before the patients received medical attention. "In one case a patient was admitted to the accident ward and 8 hours and 40 minutes later he was admitted to the hospital to have a foreign object removed from his ear."

Finally, several cases which required the attention of a resident physician were delayed because either "the residents on duty were in conference or because the resident had left the hospital without informing the telephone operator or a responsible person in the department which they were covering, where they were going, thus making themselves unavailable." Also, "it was observed that some physicians either do not hear their page or ignore it."

Recommendations

1. An extensive effort be made to acquire more black and white American physicians.
2. That patients have priority over conferences which require the presence of on duty residents.
3. That a booklet be developed which explains the function of the E.R. and that it explain the need for delays.

Operation Create (Cultural Enrichment for Neighborhood Children)

The short-range objective of the program was to provide a rewarding and meaningful "cultural enrichment" experience for neighborhood children, through stressing the creative aspects of learning rather than the mechanical. The long-range objectives of the program were to develop community interest, rapport and the expertise with the hope of making the hospital a more meaningful institution sensitive to the needs of the community in which it is located.

"Operation Create" consisted of 7 weeks, divided into two sessions. Forty children participated. The program was conducted Mondays through Fridays.

The program included the following activities: Choral singing, physical education on records, reading book corner, finger painting, murals, collages, interpretive painting, sewing, etc. Also, a Red Cross volunteer worker gave 5 hours of instruction, complete with films of instruction, on safety in the home, child care and personal hygiene. In addition, the children were given practical suggestions on how to handle fires and burns by the local fire chief.

The children were taken on field trips to the following places: Robin Hood Dell (the children's concert), Lankenau Hospital to see the Health Museum Exhibits, St. Joseph's College-Moliere's comedy "The Patient Pretends" adapted for juvenile audiences, the Art Museum, Abbotts Dairy, the Philadelphia Evening Bulletin and other sites of interest. Recreation was provided for them through trips to the Westtown camps and the Sherwood Recreation Center.

As a result of the varied and interesting activities provided for the children, tremendous community interest was generated by the program. Many parents visited the center and requested that their children be included next year if the program was continued.

"Operation Create" was concluded with commencement exercises for the group. A program entitled "A Message Through Song" was presented after which certificates of merit were given by the hospital administrator.

Section III

PROJECT WORKER PERSONAL CONTACTS

Jon Snodgrass

Introduction

From the outset the research phase faced two major questions: (a) how to evaluate the effect of student activities on the institutions and organizations with which they dealt, and (b) how to collect relevant information helpful to concerned agencies of the Federal government who might realistically begin to reform the health system in the future.

The very diversity and complexity of PSHO prevented easy answers to these questions. For example, PSHO had planned to introduce 80 health science students, 20 community workers and 20 youth interns to 40 different project sites. The number of persons at each site would vary, the function of each at the sites would vary and, of course, the nature of each individual would vary. At first and for a considerable period of time, the project appeared to be too diverse and complex for any evaluative research to be conducted. It was impossible, for example, to develop a standardized reporting procedure for feedback because the projects were so diverse that no common questions pertinent to all participants could be asked. Previous research had asked students to prepare a log or diary to be reported periodically from which data could be collected. However, these researchers had learned that students soon lost interest in maintaining a personal account of their activities so that by the close of the project only a minority had made consistent and valuable reports.

An answer to the first question was never found by the present research, but one potential answer to the second came to light during the presummer research planning. After considerable discussion among the researchers, the staff and a few health professionals, the idea of viewing the health delivery system as a process within which there were presently various points of friction came to mind. The idea was taken to the Washington Conference of June 8-9 where it was favorably received by several of the social science consultants. Later, their recommendations as to how the projects might be evaluated included the notion of periodic contact reports which would reflect the points at which the health care process was poor or inoperative.

Basically, the idea was to view the consumer at one end of a dimension of health service and the institutions of delivery at the other. Theoretically, it was thought that at certain points along this dimension, health care was quite highly developed or at least adequate in comparison to other points in the process at which care is extremely poor or completely absent. Student placements in PSHO would be involved with community organizations or official institutions which dealt directly or relatedly with the health status of the consumer. In this capacity we felt that it was possible to consider students as participant observers of the health delivery system, in a position to report on which aspects seemed adequately developed, inadequately developed or completely overlooked. In an effort to systematically uncover information in this area, the researchers reasoned that if students were able to make brief reports on the nature and purpose of each individual with whom they came into contact, a picture of the points of consumer grievances and satisfactions would come to light.

The research, however, did not have the resources or the personnel to carry out this plan at every site. Consequently it was decided to experiment with the idea of personal contacts revealing the health system deficiencies at two sites for a 2-week period. If this approach to the investigation of medical services proved successful, then it might be improved and employed in future SHO research.

Appendix 5 is a copy of the Philadelphia Student Health Organization "Personal Contact Sheet." It contains a checklist by which the respondent can quickly give the biographical characteristics of the person contacted, how the contact was established, the purpose of the contact and a means for reporting the consequences of the contact. The reporting form was designed to be brief enough so that students would not be reluctant to complete it following each personal contact, yet substantial enough to indicate whether the outcome of a contact revealed a complaint or a compliment for the health care system.

Two sites for the exploratory use of the personal contact sheet were chosen, the St. Christopher's Child and Youth Comprehensive Care Center and the Spring Garden Community Center, both located in North Philadelphia, St. Christopher's C & Y Center employed all three types of PSHO participants, three health science students, one community worker and one youth intern. This site was chosen in the hope that by multireporting, the three varieties of project worker would shed light on the delivery system at this institution. Unfortunately, the youth intern at this site was not responsive to our request and did not file contact reports.

The Spring Garden site also had a variety of project workers; one male and one female health science student and two youth interns. Here again, however, we did not receive the cooperation of the youth interns and their contacts and perspectives of the health delivery system remain unknown.

The project workers at these two sites were asked to complete a contact sheet for a 2-week block of time, (August 12-16 and August 19-23) on each person contacted either by phone or in person. The results were collected during the final conference and subsequently analyzed and collated. The analysis which is presented below is a description of the variety, nature and outcome of contact made by these project workers. The report is organized according to the type of contact made by each project worker, such as city official, community resident, and medical professional.

The reader can judge how valuable these descriptions are in the collection of information helpful to the Federal Government in improving the health care system. However, in the final section the researcher has commented on the value of the "Personal Contact Sheet" as a research instrument in collecting such information, and its potential as a research device for future SHO research.

St. Christopher's Child and Youth Comprehensive Care Center

First Health Science Student

1. City Officials: During the 2-week period, there were 15 contacts with Philadelphia city officials, a total of eight different Philadelphia governmental officials.

The contacts were all associated with cases of lead poisoning in renovated public housing units. The health science student stated that a specific accomplishment as a result of these contacts was: "The presence of lead poisoning and the need for immediate relocation of families with lead poisoning was brought to the attention of the health department." Also an appointment to meet personally with a responsible city official to examine the issue of lead poisoning was made. There was no indication that the student was successful in relocating a specific family which was the victim of the lead poisoning within the two-week period.

2. Community Leaders: One contact with a community leader in person in effort to obtain information and advice on how to approach the health and housing departments concerning the cases of lead poisoning.

3. Health Professionals: Three contacts with health professionals were established in order to obtain information on the relocation of the cases of lead poisoning.

4. Community Residents: The health science student had contact with three community residents during the 2-week period. One contact was with the woman involved in the lead poisoning mentioned above. In a second contact, the worker collected information for a

woman's public housing application and in the third, discussed the career opportunities and further education of a 14-year-old Negro male on the verge of quitting school. The health science student remarked that he was successful in getting the contact interested in investigating chances for further education before dropping out of junior high school. . . ."

5. State Government Officials: A personal contact was initiated with the Department of Public Assistance which was successful in having the allotment of a welfare recipient increased to include a dependent child.

6. Community Groups: The health science student met with one high school drill team composed of both male and female teenagers and one Puerto Rican boy's social organization to show and discuss a film on venereal disease and sex education.

Adult community workers of two different community organizations were shown the film which was also followed by discussion sessions.

Health Professionals: There were several contacts with health professionals for numerous reasons.

Second Health Science Student

1. The director of St. Christopher's Children and Youth Center was seen personally to discuss and revise the informal review clause practiced by the Patient Care Review Board.

2. Later in the week, a personal contact was made with a professor at Hahnemann Medical College from whom two films, "Labor and Delivery" and "Natural Childbirth" were borrowed.

In a third instance, the health science student personally contacted a female official of St. Christopher's Children and Youth to set up an on-going sex education course in the fall. He offered to her "a resumé of our class materials and resources." The student indicated that the official was very interested and cooperative, but he personally had some reservations about the complete success of the contact. The same individual was contacted several days later and, through her, arrangements were made to show a film on childbirth to a group of nurses.

Other PSHO Project Workers: Over the course of the 20-week period, this particular health science student made several contacts with other PSHO project workers on a number of issues.

1. He established contact with a health science student at another site and pursued the possibility of developing a sex education course. Several films were later reviewed for their possible incorporation into the course.

2. He was in contact with a variety of other PSHO workers at his site placement, a neighboring site, and with PSHO staff in order to discuss the admission policies of various Philadelphia medical schools and to discuss what action and contributions they might collectively make toward improving these policies.

3. The health science student called several meetings of other members of the child and youth site to discuss, outline and write their site problem paper.

4. The health science student initiated a meeting with three other members of PSHO who were also enrolled in the same medical school to discuss the possibility of creating a "humanitarian program" for their medical school in the fall and to investigate this particular school's black admissions policy.

5. He attended a sensitivity training session with other student participants and institutional residents at Eagleville Hospital.

NonHealth Professionals: A personal contact with the head of social work department at St. Christopher's Children and Youth Center was made and a time arranged for the social workers to view the childbirth films.

A going-away party for a nonhealth professional was held one afternoon at which the health science student had contact with numerous doctors, social workers and other personnel of the St. Christopher's Children and Youth Health Center.

Medical Technicians: The health science student met in person with one medical technician of St. Christopher's Children and Youth Center after having shown the childbirth film and discussed her attitude toward childbirth and toward sex in general.

Community Youth: The health science stuvisited the home of a female community resident in an effort to find her son, the leader of a teenage gang. The son was in St. Christopher's Hospital recovering from a gunshot wound received from another gang member. The health science student visited the gang leader at the hospital and had him select the sex education movies to be shown to his gang. The following week the gang leader was seen in his home to discuss a date for the films. At this meeting the health science student reported that they talked about retribution against another gang that shot him 2 weeks ago.

Several days later, a group of about 10 gang members met at the branch of the Public Library for 3 hours with several health science students and a physician from Hahnemann Medical College in which the films on childbirth were shown, models of the uterus and pelvis were discussed and questions answered.

This same format was followed with three other local gangs during the course of the 2-week period, a total of about 35 gang members. On the whole, the health science student reported that the members of the gangs felt the experience to be interesting and succssful.

At the outset of the 2-week reporting period, the Health Science Student conducted sex education classes with a local teenage baseball team. There was more extensive contact with this particular group than with the others. The health science student had previously established a relationship with the local baseball team.

Community Leaders: The health science student was contacted over the telephone by a community leader who was the chairman of the St. Christopher's Children and Youth Health Center Advisory Board. They agreed that a suggestion box was needed for the grievance committee in the health center. Approximately a week later, the health science student contacted the leader and together they sawed the pieces of wood ncessary to make a complaint box. Later, the box was actually built and sanded by the health science student. On several occasions between these two meetings, the committee leader was seen twice personally; once to investigate the bylaws concerning the Patient Care Review Board and, secondly, to invite him to attend an evening meeting of PSHO's Committee for Black Admissions.

The health science student personally contacted the pastor of Holy Cross Lutheran Church who "refused to lend his take-up reel for our films on sex education." The take-up reel was borrowed later that day from a leader of the Hartranft Community Corporation after an in-person contact and request were made.

The health science student telephoned the Childbirth Education Association requesting a film on childbirth and asking that the central fee be waived. The contactee responded that the film committee would look into the possibility of using the film. There is no notation by the student as to whether he was eventually successful or unsuccessful in this request.

Another community leader, the organizer of a drill team, was contacted in person to arrange for a meeting with the team to show films and discuss sex education. As described below the meeting of the team was held a few days later.

The health science student had previously established a relationship with the members of a local teenage baseball team, so that at the outset of the 2-week reporting period, sex education classes were held with this group. He played a few innings of baseball with the team after which the players participated in sex education classes. Over the 2-week period, four classes were held at which a total of five films were viewed, each of which was followed by a discussion session.

The sex education films and discussion sessions were also conducted with other groups and associations. On one day, the film was seen by three different groups, Negro, and Puerto Rican females, and on another day six family health workers from St. Christopher's Children and Youth Health Center saw and discussed the films. The film was also shown to eight members of a local girl's club. On another occasion, the student took the film to a biology class at Gwynedd Mercy College and presented it to a group of 25 students and faculty.

Third Health Science Student

The third health science student was involved mainly in the establishment of a camera club at St. Christopher's Children and Youth Center. During the 2-week period, he reported repeated contacts with young high school students interested in learning about photography and establishing a permanent camera club. His activities were in association with four Negro male and two Negro female teenagers and three Puerto Rican male teenagers. Also involved were an 11-year-old Puerto Rican girl and a 10-year-old Puerto Rican male. The health science student carried out a number of different projects with each of them, all of which seemed to center around the instruction of photography. In addition, they designed a photographic display for the waiting room of the community health center, and worked on a picture story of PSHO. Equipment for the permanent club was sought and a name for the club, "Camera & Youth Studio" was decided upon.

The student was in contact with two adult members of the community who he hoped would like to take charge of the club and see that it continued after the close of the summer.

Another community resident was contacted in her home in order to take pictures. The health science student reported that, "The pictures would be used in an approach to city agencies to have the house fixed."

Preceptors: The health science student had several personal contacts with his preceptor in an effort to obtain the names of persons who might be interested in continuing the camera club in the fall. One other preceptor was briefed on two occasions about the nature of the final conference at which his attendance was urged.

Health Professionals: Three different health professionals at St. Christopher's Children and Youth Center were contacted in an effort to provide for the continuity of the camera club. During the 2-week period no solution to the problem was obtained.

The health science student also came into a wide variety of health science personnel at a farewell party conducted at the institution one afternoon. Approximately 40 people of all races and from a wide variety of occupational status were present.

City Government Officials: A group of teachers were contacted while on tour of the St. Christopher's Children and Youth Center. The health science student discussed with the principal of Hartranft School about the further development and continuity of the camera club. In an effort to follow up the possibility, the health science student attempted twice by telephone to contact the principal of the Hartranft School in order to describe the camera club activities and status and to possibly work out a solution of its continuity. In both cases, he was not able to get beyond the principal's secretary, who twice refused to provide a telephone number or address at which the principal could be reached.

The health science student was also in contact with the director of educational services of the Philadelphia and Montgomery County TB and Health Commission who was interested in obtaining prints of housing and lot conditions to be used to display to persons with whom he officially comes into contact.

Other PSHO Students: The health science student met with two PSHO workers from another site and discussed in general PSHO plans for the fall of the year. He later talked to different area coordinators about the plans for the final conference. Another telephone contact involved one of the PSHO directors and the plans to show the Children and Youth Center to out-of-town visitors. This health science student was also in frequent contact with the youth intern at the site and numerous conversations covering a wide range of subject matter. Finally, on one occasion, the health science student along with the PSHO committee went into the neighborhood to take photographs of the housing conditions.

Community Worker: The community worker completed a series of contact sheets; however, some of them were incomplete or else too vague to give a complete picture of her 2-week contacts. She was primarily in contact with community residents and community leaders in reference to a number of issues centered around housing conditions and welfare rights.

Community Residents: On one case she took a Puerto Rican female to a welfare agency where she was successful in having the welfare grant increased to include a dependent child. In two other instances she obtained permission from two community residents to take photographs of unfit housing conditions. She contacted several community residents by telephone to give information concerning hearings which the residents were unable to attend. In two other cases, she went to the homes of community residents to learn the status of the residents' applications for public housing. She also attended several local meetings as resources to further her work with housing conditions.

Community Leaders: The community worker also met with several community leaders, particularly ministers, to arrange meetings to organize community members to obtain improved housing conditions.

Community Organizations: During the 2-week period, the community worker became an associate member of the Welfare Rights Organization and worked with them to organize for the improvement of housing conditions.

Health Professionals: The community worker came into contact with a number of health professionals in the 2-week period; in some cases made arrangements via telephone for dental services for community residents; in other cases she made contacts in person or by phone with officials responsible for public health and public housing. She also attended a lecture on environmental health delivered by a health professional, and a lecture on housing at the University of Pennsylvania.

Spring Garden Community Center

This female health science student noted that the contacts which are summarized below "were made at the end of our project period, when the clinic had closed for the month of August; they are not necessarily typical of those contacts with community people we had been making in the beginning."

In reporting the results of this student's contacts, the material has been organized in terms of the person contacted rather than the type of person. Most of the contacts were of a patient-advocate nature.

Mrs. R: Mrs. R. is a 36-year-old Puerto Rican living in the neighborhood of the Spring Garden Community Center, who came to the center with a letter from the Philadelphia Housing Authority. The health science student translated the letter into Spanish, which apparently stated that housing was available. From the contact reports it is unclear; either the housing required a $25 deposit or Mrs. R. felt that she needed this sum in order to make arrangements to inspect the housing and secure it. The health science student telephoned the city official who had written the letter to Mrs. R. and found that the official was away for a week. The health science student then spoke to another official and "explained to her that Mrs. R. did not have the $25 to come and see the house now. The official replied that they could only hold the apartment for a short time and then would have to open it to someone else."

The next contact with Mrs. R. by the health science student was the following day in which they had discussion about selling Mrs. R.'s radio-record player. The contact sheet does not disclose whether the radio-record player was in connection with the funds needed to visit the public housing or not. The student reported that "I have the feeling that Mrs. R. will not find anyone to buy her record player and will continue making the payments on it which she really does not want to, because of being on welfare."

Approximately 1 week later, Mr. R. came to the center and informed the health science student that she could not attend a clinic at a nearby hospital by herself because of the many other problems she has. "She asked me to go along — I explained the value of going alone and reporting back to me how she feels it went." At that time the student did not think Mrs. R. would attend the clinic.

After Mrs. R. left, the student telephoned a nurse at the clinic and informed her of Mrs. R's reluctance to come to clinic and clarified that since she is in the maternal and infant care program, she need not be there until 12:30, although the appointment card reads 11:15. The student also asked that the interpreter be on the lookout for Mrs. R. The health science student also noted that the clinic had become more cooperative with her and had followed some of her suggestions on specific patients since the time the student had personally accompanied them to the clinic earlier in the summer. In spite of this, the student believed that the obstetrics clinic process needs a total revision for all patients.

An hour or so later, the student again called the nurse at the clinic concerning Mrs. R. and learned that she had just been seen by the physician. The student noted "this was the first time to my knowledge that Mrs. R. was seen so quickly in the clinic."

Mrs. R. stopped by the community center after her visit to the clinic and talked to the health science student. The student suggested that "Mrs. R. had proved to herself that she could go to the clinic alone regardless of the language and cultural barriers she might encounter there and on the way."

There are no further contacts reports with Mrs. R. during the 2-week period. Whether she was successful in obtaining public housing is unknown.

Officer S.: The health science student called the community relations officer of the Philadelphia Police Department and learned that they had no record of a letter written by the student asking for an officer to speak about the police and community relations, to a meeting of PSHO students.

An officer of the community relations office returned her call later that day to let it be known that he could not speak on the day requested. A health science student told the officer she would find out what other date might be scheduled for the SHO students.

The following day, Officer S. called the health science student to ask whether a definite date had been arranged. It had not, so the student promised to call back as soon as the date was established. After discussing the problem with the area coordinator, a date was established and Officer S. was informed.

Several days later the student again telephoned Officer S. to confirm the date and the topic and 2 days following, the officer spoke at the Hahnemann Medical School Auditorium to a group of SHO students.

Mr. and Mrs. L.: The health science student had been in continuous contact with the L. family during the summer. During the 2-week reporting period, she was involved in obtaining treatment for Mr. L., a 30-year-old Negro at a mental health clinic and oral surgery for Mrs. L. The first contact during the 2-week period in regard to the L. family was to telephone a public health nurse to brief her on the L. family in order to provide continuity of care once the health science student completed her summer assignment.

She next went to the L.'s home and informed Mr. L. personally of an appointment she had set up with the Community Mental Health Clinic. She also discussed his progress in obtaining public housing and informed him that she would be leaving soon and that the public health nurse would take over his case.

She then called the mental health clinic, thanked the nurse for setting up the appointment for Mr. L.

The following day the health science student visited the L.'s home to discuss the results of the appointment with the mental health clinic. At that time they also discussed the possibility of having his wife admitted to the hospital.

The health science student later spoke to a medical secretary to learn how Mrs. L. might be admitted to the hospital for surgery. The secretary offered to contact a doctor who could explain admission procedures. A doctor from the hospital called later and "suggested that Mrs. L.'s other medical problems be handled before her oral surgery." The health science student explained Dr. R.'s deferral of her oral surgery. Her possible admission was to be discussed with another doctor. The health science student stated that she had arranged to page Dr. S. the following day to find out what doctor would perform Mrs. L.'s surgery and when she might be admitted, but there is no indication whether this was done or whether Mrs. L. received the surgery.

Several days later the health science student received a telephone call from the doctor at the mental health clinic with whom she discussed Mr. L.'s case.

On the same day Mr. L. came by the Spring Garden Community Center "to thank me for having helped him and his family. The fact that Mr. L. sought me out to say goodbye I feel was significant—apparently he feels our contact with him this summer has been on a person-to-person basis and that he has made some progress."

Mrs. M.: "Mrs. M. (a 30-year-old Puerto Rican) called me over when she was waiting with her son at the clinic. She asked me to inquire when her son would be seen, since she had been waiting 2 hours already (she did not speak English). When I explained this to the nurse, she and her son were seen immediately so that she could get home to her other children before it got too late. Actually this is not much of an accomplishment (the intervention of a health science student) because it is not remedying the situation of long waits that almost all patients at the clinic must endure."

Mrs. C.: A 28-year-old Puerto Rican came to the Spring Garden Community Center seeking health care for her son. The community center could not provide the care, so the health science student called the pediatric clinic at a nearby hospital and obtained information on how Mrs. C.'s son might receive treatment. The student informed Mrs. C. of the procedure and referred her to the hospital clinic.

This health science student had numerous other contacts durnig the 2-week period aside from those associated with patient advocacy. She worked with a mobile X-ray unit working in the Spring Garden area, attended a sex education seminar with other PSHO students which explained how one hospital is teaching this topic in the Philadelphia public schools, toured a hospital museum and worked with several other PSHO members to develop a schedule of meetings and speakers for the final convocation.

Second Health Science Student

The contact reports filled in by this health science student were done in a perfunctory and cursory fashion so that it is difficult to establish the purpose and accomplishments of his work activities. During the first week, he apparently worked closely with health professionals of a mobile X-ray unit, although the specific tasks remain vague. He also had frequent contact with a female Puerto Rican over the 2-week period who was a community worker although the reasons for contact are not spelled out. He was in continuous contact with two other PSHO students of another project to discuss and help carry out a project survey. Other than these issues, the other contact reports filed by this particular student are not especially valuable in understanding points of grievance in the health care delivery system.

Section IV

SHO'S SHOW: AN EVALUATION OF THE 1968 PHILADELPHIA STUDENT HEALTH ORGANIZATION SUMMER PROJECT

Jon Snodgrass

Introduction

The title, "SHO'S Show," may imply that the 1968 Philadelphia Student Health Organization Summer Project was a ludicrous carnival, or it may imply that it was a remarkable demonstration in social reform. Possibly it implies both, perhaps neither. In any case, the title is left sufficiently ambiguous to allow the reader of this report to come to his own conclusions by critically examining the data in this section.

The report can be read on two different levels. The reader can view it as factual, empirical material about the 1968 PSHO project. Or the reader can view it as a specific example of larger historical trends in society.

On an empirical level PSHO was composed of 74 health science students, five area coordinators, three directors, 21 community workers and 20 youth interns who worked with a total of 34 community organizations and health and welfare institutions within the city of Philadelphia.

On a general level PSHO was composed of a group of individuals in an attempt to improve the social conditions of relatively few victims of the 20th century.

On an empirical level the evaluation reflects that PSHO had mixed results—successful and unsuccessful.

On a general level the actual results appear insignificant in comparison to **the attempt.** The importance of PSHO lies in the attempt to miprove the conditions of less privileged men caught up in the human race, regardless of whether the attempt is a grand success or dismal failure.

In locating PSHO's relevance to larger societal trends, one of the most outstanding and curious features of the project was the nature of its financial support and the character of its participants. The administrators and participants were almost entirely youth, while those funding the project were primarily adults. It is this fact, it seems to the researchers, which contains PSHO's relevance to the broader society. It struck the researchers time and time again throughout the summer that the relationship between the adults and youth in PSHO was somehow only a reflection of a larger trend in society. A trend in which it seems that adults not only identify strongly with youthful life styles, dress and ideology, but place great hope in the present generation to attain a conflict-free society and secure the basic rights of men. This is not the "generation gap." The generation gap is an old phenomenon, widely covered (but never bridged) by the media and generally acknowledged by the public. Even 170 years ago de Tocqueville, the French scholar, was aware of the generation gap when he stated that in the United States, "The tie that unites one generation to another is relaxed or broken; every man there readily loses all trace of the ideas of his forefathers or takes no account of them." But the contemporary relation between the generations as reflected by PSHO seemed to indicate that we have moved beyond the generation gap to what we can only describe as the "generational inversion." De Tocqueville saw that the classical relationship between adults and youth would be fractured, but not that they might be totally inverted—he did not foresee the possibility that the forefathers might imitate the traditions and ideas of their offspring.

There presently is much debate over the meaning of active and protective movements of youth. On the one hand the vast majority of people overtly claim that this is the undisciplined response of the permissive generation constrained to act out of the boredom of its affluence. On the other hand, but beneath this general assessment, there seems to be a minority, but growing number of individuals, who claim that this is the generation of hope; the generation which can achieve permanent solutions to the many and complex problems which increasingly plague modern civilization. There appears to be a subtle and gradually emerging belief that youth are prodigies who can ingeniously resolve the social pathologies of contemporary society.

The generation inversion is seen, for example, in a statement by Margaret Mead, the well-known anthropologist, who said, "What's happening now is an immigration in time with the people over 40—the migrants into the present age, and the children born in it—the natives." It is also evidenced in the comment by an official of the U.S. Department of State who remarked, "These kids are all trying to tell us something—and we better damn well figure out what it is." Similarly, an eminent fashion designer recently quipped that, "It used to be that the son who sneaked in to borrow his father's tie, now the father is sneaking in to borrow his son's turtleneck." And also by a housewife who reflected, "I believe this whole generation of young people is saying to us, in effect, 'Look, you use beautiful words and do ugly things; we'll take ugly words and make beauty out of them.'"

Should the exchange be simply one of clothes, or but old vulgarities seen as new virtues, statements of precaution would be improper. However, the inversion permits the older generation to resign its responsibility for building a better society. The reliance and expectation placed on youth imply a resignation, if not acquiescence by adults. This means that the burden of social reformation rests heavily on the shoulders of youth alone. Within the field of medicine it means that the passing generation of medical professionals can remain inactive observers as their youthful successors attempt to improve the field of medicine.

If PSHO is a representation of a general societal trend in which adults rely on youth, then one has in this report, on the general level, material which would indicate whether the social reforms so urgently needed have been discovered by youth. If the generational inversion permits acquiescence by adults, we fear that the reforms will not be implemented, but held in abeyance awaiting the initiative of youth. Whether all youth will take up the initiative is doubtful; whether enough youth alone can match the expectations of the adults is at least uncertain. But efforts by both, either independent or in unison, seem far more promising. Without broader, transgenerational efforts in social reform, the generations may not continue to invert, but both dissolve amidst the crises in society.

These comments are not restricted to the empirical aspect of the research but apply to the total evaluation—the qualitative portion reported by Miss Karen Lynch in section II and the qualitative portion in the present section.

As to the empirical aspect of the research, it has been directed toward, first, a social-biographical description of student participants, and second, the impact PSHO summer project has on student attitudes, student education and student future careers. Of these three, the change in student attitude has received the greatest study, out of necessity more than choice. The impact of PSHO on student future careers was beyond the individual ability of the researchers, beyond the financial resources of the project and perhaps beyond the capacity of social science research, at least in its present stage of development. To learn whether a 10-week work experience altered students' career direction would minimally require a longitudinal study with a carefully matched control group—a very ambitious undertaking. The most the researchers have been able to do in this regard is ask students to project the direction of their future careers and to subjectively estimate what influence PSHO has had in shaping that direction.

To know what effect the project has had in increasing student knowledge and broadening their education assumes that one knows before hand what will be learned and can devise methods to measure the quantity and quality of learning. Since PSHO has been organized predominantly by students of medicine, there has been a great interest is discerning what students have learned with regard to subjects within the field of medicine. Unfortunately, previous research has not been able to devise means of measuring the quality and quantity of knowledge gained and thus has had to rely primarily on students' subjective estimate of the amount learned; as, for example, by asking "how much did you learn about health care in an urban setting," "health problems of the poor," "politics and health care" and so on. While certainly students' judgments are reliable indications of learning, these estimates are not conclusive in themselves. Unfortunately however, the present research has not been able to avoid this dilemma and students have therefore been asked to judge the amount and type of learning provided by PSHO.

Out of default then, rather than enthusiastic disposition, the present research has attempted to evaluate the impact of the PSHO experience on student attitudes. The measurement of attitudes has also been attempted by previous SHO research largely without success. The 1966 California SHO research, the most highly developed in this regard, attempted to measure the change in student attitude toward a variety of medical and social issues.[1]

The two major limitations of that research, (a) the absence of a control group with which to compare attitude change, and (b) the absence of a technique by which to control for or at least account for student selection procedures which tend to choose students already favorably predisposed toward the attitude in question, have both been partially corrected in this research. In the following year, 1967, the California evaluation also concerned itself with attitude change. No conclusions could be drawn in this case because scoring keys were not available. Item analysis, however, indicated that a change in attitude from pre-test to post-test occurred on only a limited number of questions.[2] The present research has attempted to rely on this past research, using their experience as a guide as to what pitfalls to avoid and what errors to correct. Both limitations of the California 1966 project have been improved upon but not completely resolved.

In the following pages then is the empirical portion of the evaluation of the 1968 Philadelphia Student Health Organization Summer Project. It is composed of several parts:

The background characteristics of the 74 health science participants and the eight staff members.

The influence that PSHO has had on student education and careers.

The results of the administration of several attitudinal tests to the participants, both before and after the summer-work experience.

A few of the accomplishments of the students over the course of the summer and their reaction to PSHO as an organization.

A comparison of the attitudes of 39 medical students in PSHO with 38 medical students not participating in PSHO, as they were measured both at the beginning and conclusion of the project.

Background Characteristics of the Health Science Students

Introduction

Presented here is a description of the background characteristics of PSHO participants along with a modest comparison of what is known about the background characteristics of members in other students' movements. Also a few notes of comparison on the composition of the Philadelphia 168 project with previous SHO projects in other cities.

Methodology

During the initial orientation held June 21-23, 1968, at Eagleville State Hospital and Rehabilitation Center near Norristown, Pa., a questionnaire consisting of biographical items and a battery of five attitudinal tests containing 185 questions were given to the majority of students on the first day immediately after registration (see app. 1 and 3). For those who arrived at orientation late, the questionnaire was given to them to answer as soon as possible. By the conclusion of the orientation, 62 of the 74 students who were eventually to participate in the projects had completed the questionnaire. The 12 students who were not sampled are those who did not arrive, or were not hired until after orientation, or were either unwilling or neglectful in completing the questionnaire during orientation. A decision was made not to follow up the unsampled 12 since the orientation period contained a great deal of activity and discussion which might promote attitudinal change. It was felt that anyone not present at orientation would not be exposed to the complete range nor the full intensity of the summer project and might consequently tend to neutralize attitudinal changes should their responses be compiled along with those exposed to the orientation.

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[1] *The Student Health Project, USC-SMC Student Health Project 1966*, publisher unknown, December 1966.

[2] *Evaluation of the California 1967 Student Health Project*, mimeo., n.d., p. 24.

On the other hand, data on the background of all 74 student participants is available. A word of explanation, however, is needed concerning the total number of students: of the original 74 students to begin work at project sites, four dropped out during the course of the summer for various personal reasons or because of illness. Below are described 73 of the original 74 project fellows, plus one individual who was employed as a replacement very early in the summer. Also described separately are the background attributes of the five area coordinators and three student directors who are jointly reported under the heading of "staff."

The term "health science student" is somewhat of a misnomer in describing the field of study of the participants. Roughly 65 percent are osteopathic and medical students, and an additional 12 percent encompass nursing and dentistry. However, there are also representatives of a wide variety of academic disciplines only indirectly related to physical health such as communications, counseling, psychology and anthropology. The term "health science student" is used for convenience with the understanding that it refers in this context to all students participating in the project.

The model response of health science participants indicates that they have their origin in the Philadelphia area from Jewish families which are predominantly middle and upper class and whose father is a medical professional or a businessman earning on the average over $15,000 yearly.

The data which follow describe the characteristics of the students and staff, and their background in greater detail.

Reason for Participation

Students were asked both at the opening orientation and at the closing conference to rank three major reasons for participation in PSHO. In all, there were four dominant interests: (1) to learn about community medicine; (2) to learn about urban slum conditions; (3) to bring about social change; and (4) to help the poor. In the beginning, almost one-half selected either the opportunity to learn about community medicine or the opportunity to learn about urban slum conditions, as their major reasons for participation. These were also the first and second choices respectively of over one-third of the students. This would indicate that students perceived the summer project mainly as a learning experience. Approximately one-third also selected two altruistic reasons, creating social change and helping the poor, as among the three primary reasons for participation. These two were among the highest first and second individual choices. Initially then, students seemed to have joined primarily for the educational value, and secondly for humanitarian interest in community welfare. Personal reward such as earning $900 and living in Philadelphia took lower priority originally.

The response to the reason for participation changed somewhat, however, by the time of the closing conference. The emphasis on learning and creating social change remained relatively constant but the interest in helping the poor dropped from the fourth most frequently mentioned to the ninth position. This shift is not readily explicable. It may, perhaps, indicate a change in the expectations of what realistically can be accomplished in ten weeks. Moreover, twice as many students in the closing session indicated an interest in income as being among the three major reasons for participation than did originally. Another curious fact is that concern with advancing civil rights was among the lowest justifications for participation originally, and while this increased slightly over the summer, it remained a minor reason for student participation on the whole.

The data concerning reason for participation both before and after the summer project are shown in table 1. In general, students initially gave educational and altruistic reasons for participation; for the most part, this remained constant over the summer with the exception of interest in helping the poor which declined and personal interests which increased slightly.

Table 1.–Student's Reasons for Participation, Before and After.

Reason	Priority of reason							
	First		Second		Third		Total	
	Before	After	Before	After	Before	After	Before	After
	Percent	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*
The opportunity to:								
Learn about community medicine	34.4	27.6	21.3	19.0	9.8	17.5	21.9	21.4
Learn about urban slum conditions	19.7	19.0	36.1	15.5	13.1	15.8	23.0	16.8
Help bring about social change	14.6	20.7	16.4	15.5	18.0	10.5	16.4	15.6
Help the poor	11.5	1.7	11.5	8.6	24.6	3.5	15.8	4.6
Associate with health science students	3.3	5.2	4.9	6.9	8.2	14.0	5.5	8.7
Earn $900	1.6	6.9	6.6	10.3	8.2	15.8	5.5	11.0
Help advance Civil Rights movement	3.3	1.7	....	8.6	8.2	8.6	3.8	6.4
Live and work in Philadelphia	3.3	10.3	1.6	5.2	4.9	7.0	3.3	7.5
Work with a practicing health science professional	3.3	1.7	....	6.9	3.3	5.3	2.2	4.6
Other	4.9	5.2	1.6	3.4	1.6	1.8	2.7	3.5
Total	99.9	100.0	100.0	99.9	99.9	99.8	100.1	100.1

N Before=61. N After=58.

Origin of the Students: The majority of the student participants considered Pennsylvania, particularly Philadelphia or its surrounding suburbs, to be their home. Most attended a university or medical school in the city of Philadelphia. There were, however, some whose home and school of attendance were quite distant. For example, four nursing students came from San Jose, Calif., one medical student from Milwaukee, Wis., and one nursing student from Rochester, N.Y. In a few instances, students who considered Philadelphia to be their home studied at universities outside the State and had returned to the city for the summer to participate in the project.

Age: The age of the great majority of students was concentrated in a very narrow range of 3 years. Almost 65 percent were between the ages of 21 and 24 years. The most frequently reported age was 22 years and when this is broken down categorically into months, the most common age is closer to 23 years. The student project administrators too were approximately the same age as fellow participants. Table 2 following reflects the distribution of ages of the 74 health science students and the eight members of the staff.

Table 2.–Students and Administrators.

Age	Students		Staff	
	N	Percent	N	Percent
Up to 19 years	4	5.4	....	....
19 to 20 years	6	8.1	....	....
20 to 21 years	2	2.7	1	12.5
21 to 22 years	15	20.3	....	....
22 to 23 years	17	23.0	2	25.0
23 to 24 years	16	21.6	3	37.5
24 to 25 years	1	9.4	....	....
25 to 26 years	4	5.4	1	12.5
26 to 27 years	2	2.7	....	....
27 years and older	1	1.4	1	12.5

Sex and Race: The student participants were predominantly white males. The sex and race of the staff and students are shown in the table below.

Table 3.–Sex and Race of Students and Staff.

Sex	Students		Staff	
	N	Percent	N	Percent
Male	51	68.9	6	75.0
Female	23	31.1	2	25.0
Total	74	100.0	8	100.0

Race	Students		Staff	
	N	Percent	N	Percent
White	70	94.6	7	87.5
Negro	4	5.4	1	12.5
Total	74	100.0	8	100.0

Religion: Students were asked to provide information on their family religion. Table 4 depicts the religion of their family, that is, the type of religious background in which they were reared rather than their own personal belief.

Table 4.–Family Religion of Students and Staff.

Religion	Students		Staff	
	N	Percent	N	Percent
Protestant	19	25.6	5	62.5
Catholic	18	24.4	....	....
Jewish	31	41.8	3	37.5
Mormon	1	1.4	....	....
Quaker	1	1.4	....	....
Russian Orthodox	1	1.4	....	....
Eastern Orthodox	1	1.4	....	....
Atheist	1	1.4	....	....
Unknown	1	1.4	....	....
Total	74	100.2	8	100.0

Educational Experiences: Eighty-one percent of the students were enrolled in professional schools, either medicine, osteopathic, dental, law or nursing. Approximately 10 percent were in various graduate schools and 10 percent were undergraduates. Table 5 below reflects the variety of professional and graduate schools which the students attended.

Table 5.–Field of Study of Students and Staff.

Field of study	Students		Staff	
	N	Percent	N	Percent
Medicine	39	52.7	8	100.0
Nursing	7	9.5	....	....
Osteopathy	9	12.2	....	....
Dentistry	2	2.7	....	....
Law	2	2.7	....	....
Social work	2	2.7	....	....
Anthropology	1	1.4	....	....
Communications	1	1.4	....	....
Counseling	1	1.4	....	....
Education	1	1.4	....	....
Psychology	1	1.4	....	....
Undergraduate	7	9.5	....	....
Total	74	99.0	8	100.0

Over 75 percent of the students were enrolled in disciplines directly related to health care—medicine, osteopathy, nursing and dentistry.

The undergraduate majors, however, show a much wider variety of scholarship. Here, there is a greater representation of the social sciences and humanities indicating that almost 30 percent have a background in studies other than the physical and natural sciences. Table 6 displays the major area of study as undergraduates.

Table 6.–Undergraduate Major of Students and Staff.

Major	Students		Staff	
	N	Percent	N	Percent
Natural sciences:				
Biology	28	37.8	3	47.5
Pre-med	3	4.0	1	12.5
Other (chemistry, zoology)	8	10.8	2	25.0
Total	39	52.6	6	75.0
Physical sciences:				
Engineering	1	1.4	....	....
Total	1	1.4	....	....
Social sciences:				
Psychology	5	6.8	....	....
Philosophy	3	4.0	1	12.5
Sociology	4	5.4	....	....
History	1	1.4	1	12.5
Political science	2	2.7	....	....
Total	15	20.3	2	25.0
Humanities:				
German	1	1.4	....	....
English	3	4.0	....	....
French	1	1.4	....	....
Art	1	1.4	....	....
Total	6	8.2	....	....
Other:				
Nursing	7	9.5	....	....
Pharmacy	3	4.0	....	....
Physical therapy	3	4.0	....	....
Total	13	17.5	....	....
Total	74	100.0	8	100.0

Family Background: A well-known technique for determining social class[3] reveals that most of the PSHO participants are from either the upper or middle class. This technique estimates an individual's social class position based on the amount of esteem accorded by the general public to the father's occupation. Table 7 reflects the distributions of students according to social class.

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[3] The North-Hatt Occupational Prestige Scale ranks the prestige accorded by the general public to some 90 occupations. The North-Hatt Scale was divided into four equal parts each representing the upper, middle, working and low classes. A student was placed into a particular class based on his father's occupation. Where no obvious equivalent occupation is provided on the North-Hatt Scale, an estimate was made on the basis of the amount of skill and education required. See Delbert C. Miller, *Handbook of Research Design and Social Measurement* (David McKay Co.: New York, 1964 pp. 106-110.)

Table 7.—Social Class of Students and Staff.

Social class	Students		Staff	
	N	Percent	N	Percent
Upper	23	31.1	2	25.0
Middle	30	40.5	4	50.0
Working	17	23.0	2	25.0
Lower	2	2.7	....	....
Unknown	2	2.7	....	....
Total	74	100.0	8	100.0

Family Income: Combined parental income of students averaged $15,195, while that of staff was $9,312. These figures indicate that the students for the most part come from the more affluent sectors of the economy.

Table 8.—Family Income of Students and Staff.

Family income	Students		Staff	
	N	Percent	N	Percent
Up to 2,999	3	4.1	1	12.5
3,000 to 5,999	3	4.1	1	12.5
6,000 to 8,999	15	20.3	2	25.0
9,000 to 14,999	17	23.0	3	37.5
15,000 to 19,999	8	10.8	1	12.5
20,000 to 24,999	13	17.5	....	....
25,000 and over	13	17.5	....	....
Unknown	2	2.7	....	....
Total	74	100.0	8	100.0

Father's Occupation: Classifying father's occupation into several broad categories shows a wide range of occupational types as indicated in table 9 below:

Table 9.—Occupation of Fathers of Students and Staff.

Occupation	Students		Staff	
	N	Percent	N	Percent
Professional medical	17	23.0	1	12.5
Professional nonmedical	9	12.2	1	12.5
Proprietors and managers	2	2.7	....	....
Businessmen	15	20.3	1	12.5
Clerks and kindred	11	14.7	2	25.0
Manual	12	16.2	1	12.5
Protective and service	3	4.1	....	....
Deceased	4	5.4	2	25.0
Unknown	1	1.4	....	....
Total	74	100.2	8	100.0

Mother's Occupation: Most of the students' mothers were occupied as housewives, very few were professionals in the health science field, and only about 40 percent worked outside the home.

Table 10.—Occupation of Mothers of Students and Staff.

Occupation	Students		Staff	
	N	Percent	N	Percent
Professional medical	3	4.1	2	25.0
Professional nonmedical	11	14.9	1	12.5
Proprietors and managers	1	1.4	....	....
Businesswomen	1	1.4	....	....
Clerks and kindred	9	12.2	3	37.5
Manual	1	1.4	....	....
Protective and service	4	5.4	....	....
Housewife	44	59.5	2	25.0
Total	74	100.3	8	100.0

Previous Experience: Students were asked whether they previously had any experience with social action programs. Only 39 percent of the students, but 75 percent of the staff, had previously participated in at least some form of community work.

Students were also questioned as to whether they had taken coursework in comprehensive medical care or community medicine. Here approximately 15 percent of the students and 25 percent of the staff had had this sort of academic preparation.

Combining these two as indicators of an interest in social activism reveals that, altogether, approximately 50 percent of the students had either practical experience or academic coursework that might prepare them to carry out their summer work projects.

Previous SHO Comparison: It is difficult to compare the members of PSHO with previous SHO projects since the past method of reporting is considerably different or in many cases, severely limited. This is possible in a few instances; however, the composition of Philadelphia 1968 in terms of percentage of medical students is identical to that of Bronx 1967 and Chicago 1967; all three had 65 percent medical student participation. The students of Philadelphia 1968 also reported fewer Protestants and Atheists and more Catholics and Jews than previous projects. However, this may be accounted for by the fact that Philadelphia 1968 students noted their family religious background rather than their personal faith. Additionally, Philadelphia 1968 had fewer black health science students than any previous project (5.4 percent) except possibly Chicago 1967, which made no report on its racial composition.

Discussion of Background Characteristics: Using the most frequently reported characteristics as an indication of the typical health science student, one finds a 22-year-old, white, Jewish, male, student of medicine, who minored in biology as an undergraduate. He has his origin in the upper middle class and his father is a medical professional. On the average he has had no previous experience in social action programs nor substantial academic preparation for medical work in the community.

There is a growing body of research being conducted concerning student social activism and the student protest movement. One of the most frequently reported observations is that the vast majority of college students are not activists. Most students across the country seem to uncritically accept society as it is presently established, see college as an extension of high school and as a vehicle to a comfortable career. Rarely are they apparently deeply concerned with political and social issues or perceptive of disturbing social conditions in this country or abroad. Student dissent seems to occur predominantly among a minority of students in large, urban universities either in the North or Far West which are well-known for their academic standing.[4] Two recent studies by one social scientist investigated the background of 50 activists in Chicago area colleges and 65 students who sat-in at the Administration Building of one university in protest against the administration's cooperation with the Selective Service System. The findings disclosed that students involved in protest activity generally are from upper status families which are Jewish or irreligious and whose head of the household is an affluent professional.[5]

One would like to be able to compare the attributes of PSHO students with the members of activist groups to discover whether there are similarities and dissimilarities. Unfortunately, no tabulation of the biographical features of student activists is available. Impressionistically it seems that PSHO and members of student movements generally may have comparable traits in some cases and remarkably different traits in others. PSHO students were a heterogeneous group whose level of social awareness, previous experience in social reconstruction and background vary widely. Certainly some members of PSHO were deeply committed to the improvement of social conditions, others were as unseeing and indifferent as the career-bound normal student, and others yet began to emerge as among the concerned. It seems reasonable to state that students in PSHO had many characteristics in common with students in dissent groups with one notable exception. The major fields of study of most activists are the humanities or more commonly the social sciences.[6] PSHO participants are mainly medical students and even in their undergraduate careers majored in the natural sciences. Also, student activists tend to be more intellectually or esthetically oriented and not concerned with specialization in a technical field which more or less guarantees a secure and durable position in society. PSHO students are overwhelmingly oriented toward a professional career, particularly in medicine. As mentioned, over 80 percent of PSHO health science students were enrolled in schools of professionalization, either law, dentistry, nursing, medicine or osteopathy. The moderateness of the students of professions, including those of medicine in the United States, is not typical in other parts of the world. Lipset reports that medical students in Latin America and southern Europe are historically more leftist in orientation, while in northern Europe and the "Anglophonic" world they have a traditionally conservative orientation.[7] In Holland and Germany, for example, medical students' participation in reformative groups is a rarity.[8] The comparison of PSHO students with protest groups is basically a comparison between two student groups and not a comparison between two protest groups. The activities of PSHO students over the summer were more in the tradition of moderate casework-like improvement of social conditions rather than strong dissent and demand for radical change in the existing social structure.

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[4] J. W. Trene and J. L. Craise, "Commitment and Conformity in the American College," *Journal of Social Issues* 23 (July 1967) p. 35.

[5] Richard Flacks, "The Liberated Generation: An Exploration of the Roots of Student Protest", Ibid., p. 66.

[6] Trent, *op. cit.*, p. 42. And Seymour Martin Lipset, "Student and Politics in Comparative Perspective", *Daedalus* (Winter 1968) pp. 1-20.

[7] Lipset, *op. cit.*, p. 17.

[8] Frank E. Pinner, "Tradition and Transgression. Western European Students in the Postwar Period", *Daedalus, op. cit.* p. 144.

Student Education

The Goals of PSHO

The Student Health Project Proposal for Philadelphia Summer 1968 emphasized the educational importance of the project. The proposal stated that the Summer Health Project "will provide 80 health students from various sectors of the country with a new and vital educational experience." [9] Students would hopefully learn about problems of health care in indigent areas, preventive solutions to health problems, a multidisciplinary approach to health care, the economics of health delivery systems and community medicine among other issues.

Aside from education, the goals of the Student Health Organization summer projects are a complicated mattter. Primarily, the philosophy of the staff was to allow students to experience the multifaceted problems of health and the urban poor on an individualistic level, through a decentralized organizational structure with nondirective leadership. There were, then, no ubiquitous, definitive goals. The organization did not establish goals for student participants to achieve other than self-edification through firsthand experience. PSHO was designed to allow students to witness alone or in small teams the social conditions of the poor, particularly health conditions in industrial society, and from this experience create and initiate new and hopefully practical reforms. The staff itself and the office materials were available as resources to the students. The directors could be contacted for advice and recommendations on how students might approach the reform of particular problems, but the directors did not feel it their task to select specific goals, make strategy decisions and outline the aim of all project members for the total summer. The leadership did not conceive of itself as leaders but as coordinators. The organization did not have formal organization, but was flexibly organized so that students could follow their own individually conceived courses of action and it did not designate major purposes for the total project.

There were of course vague goals that various staff members held such as reforming the health care system, improving conditions of the poor, effecting social change. But these were abstract, almost bordering on the transcendental, and not intended for actual implementation unless a united movement in this direction naturally developed out of the summer's experiences. Staff and students did not fully agree on the major goals of PSHO, aside from the goal of education, and on particular issues, opinion was fragmented.

If one had to define the goals of the PSHO summer project, its goals were what each individual participant defined as his goal on a personal basis. If individual goals coincided and they desired to join together, initiate a reformative movement within the organization and draw in other members, then the structure was flexible enough to permit this to occur.

Education, then, was the primary emphasis—betterment of the poor and social reform were incidental, if not serendipitous. In regard to education, it was believed that should there be no reformative movement as an outcome, at least students had personally witnessed the impoverished conditions of the urban lower class; and students could learn how the educational institutions might be altered in order to address themselves to the medically indigent and how students themselves, once they had achieved positions of influence in the medical or professional field, might from that stature be successful in bringing about constructive change.

The research collected some data on the heuristic effects of PSHO which are presented in detail in the following paragraphs.

PSHO as an Educational Experience

As mentioned in the section concerning student characteristics, roughly 50 percent of the students joined the summer projects in anticipation of a learning experience. When asked specifically during the introductory orientation "how much do you think your summer work experience will add to your professional education," over 40 percent thought it would contribute a "great deal" and an additional 42 percent thought it would make a "considerable" contribution. However, by the close of the summer, 10 percent fewer students in each of these categories felt that the summer had matched their expectations. Moreover, almost twice as many (30.5 percent vs. 17.7 percent) thought the summer provided only a moderate learning experience in the end as they expected in the beginning. Also, while no one thought the project would have "little or no" educational value prior to the actual work experience, 10 percent felt this way at the closing conference.

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[9] *Student Health Project Proposal for Philadelphia*, Summer 1968, n.d., mimeo, p. 2.

As for the staff, all but one member expected the summer to have a great deal of educational value before the project began, but only five felt this way after the project closed. Table 11 reveals students' and staff's before and after responses to the question, "How much do you think your summer work experience will add (has added) to your professional education?"

Table 11.–Judgment of Students and Staff on PSHO's Educational Value.

Educational value	Students		Staff	
	Before	After	Before	After
	percent	*percent*	*percent*	*percent*
A great deal	40.3	28.8	87.5	62.5
Considerably	41.9	30.5	12.5	12.5
Moderately	17.7	30.5	....	25.0
Very little	....	10.2	....	....
Nothing	....	....	....	....
Total	99.9	100.0	100.0	100.0

N Students before = 62.
N Students after = 59.
N Staff before and after = 8.
Students $X^2 = 10.6$, df = 4, $p = 0.05$.

In general, both staff and students reported a decline in education enrichment in comparison to their original expectations. Chi Square calculated for students indicates that this decrease is probably not a chance occurrence, but rather a significant decrease in judged educational value. The only source of comparison is the Bronx 1968 project which asked the same question. In that project, 53 percent thought that the work experience contributed a great deal to their professional education as contrasted with 29 percent for Philadelphia 1968.[10] One should bear in mind, however, that following the summer experience, 90 percent of the students and all of the staff believed it to be of some educational enhancement.

As to what was learned, students and staff both were asked to what extent the summer experience contributed knowledge and specific skills helpful to their future careers. Over 93 percent of the students and 100 percent of the staff thought general knowledge was acquired. A lesser percentage of both groups (80 percent and 87.5 percent) felt that specific skills helpful to their career were gained. In both the cases, the experience was judged to be more valuable in the acquisition of knowledge than in the acquisition of skills. In fact, 20 percent of the students thought the summer was not helpful at all in terms of skills as contrasted with only 5 percent who felt this way in terms of knowledge. The distribution of student responses are presented below in table 12.

Table 12.–Judgment by Students and Staff of Knowledge and Specific Skills Acquired.

	Students		Staff	
	Knowlerge	Skills	Knowlerge	Skills
	percent	*percent*	*percent*	*percent*
Very helpful	35.6	18.6	75.0	25.0
Moderately helpful	44.1	32.2	12.5	50.0
Slightly helpful	13.6	28.8	12.5	12.5
Not helpful at all	5.1	18.6	....	12.5
Detrimental	1.7	1.7	....	....
Total	100.1	99.9	100.0	100.0

N Students = 59.
N Staff = 8.

Estimating the value of the PSHO in terms of student education is a difficult matter, and the above figures should be used only as rough indicators. It may be that the projects had more educational impact than students recognize or were willing to report during the immediacy of the closing conference. It is also possible that educational value may only materialize over a more extended period of time. In any case, it can be fairly stated that on the whole a great majority of students and staff did subjectively estimate that the summer program was helpful to a varying extent in acquiring knowledge relevant to their future careers.

Students were also questioned as to what they saw as the "major benefits" of participation in PSHO. The major benefit agreed upon by 20 percent of the students was the opportunity to learn about urban slum conditions firsthand. Here again, self-education is the point most heavily emphasized by students. Approximately the same percentage, one may recall, stated that they joined the program for this specific learning opportunity (see p. 88).

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[10] Ronald Miller, "*The Project Evaluated*:, *The Student Health Project of the South Bronx Summer 1967*. ed. S. Fisch & J. Williams, publisher unk., n.d. p. 188.

However, several curious facts stand out—over 20 percent of the students joined for the opportunity to learn about community medicine, but less than 4 percent listed this among the top three benefits of participation. Likewise, some 16 percent joined for the opportunity to help the poor, but only 5 percent considered this an advantage to participation. On the other hand, 20 percent joined to learn about urban slum conditions and approximately the same number agreed that this was a major advantage. Similarly, creating social change was equally considered to be a major reason for participation and a major benefit. Other advantages most frequently mentioned were: earning $900, working with a practicing health professional, and associating with fellow health science students. Data concerning the major advantages of participation are shown in table 13 below.

Table 13.–Rank Judgments of Students on Major Benefits Resulting From PSHO Participation.

Benefits	Priority of benefits (percent)			
	1st	2d	3d	Total
The opportunity to:				
Learn about urban slum conditions	30.9	14.8	13.0	19.0
Help bring about social change	16.4	10.7	14.8	16.0
Earn $900	9.1	1.11	22.2	14.1
Work with a practicing health professional	12.7	11.1	13.0	12.3
Associate with health science students	5.5	14.8	14.8	11.7
Live and work in Philadelphia	3.6	13.0	5.6	7.4
Help the poor	1.8	7.4	5.6	4.9
Help advance civil rights	3.6	3.7	5.6	4.3
Learn about community medicine	1.8	5.6	3.7	3.7
Other	14.5	1.9	1.9	6.1
Total	99.9	100.1	100.2	100.1

Any conclusions concerning the total heuristic effect of PSHO must remain tentative. Students joined mainly for the educational advantages offered. The outcome, however, did not fulfill their complete expectations and students in Philadelphia SHO felt they learned less than students in the Bronx 1967 project. In spite of this it bears reiterating that over 90 percent felt the project was *moderately* to *greatly* helpful in educating them for their future careers.

Students' Ideology

A major question in previous SHO evaluative research reports has been the degree to which the selection of students has a bias built in which naturally selects students with views already favoring particular attitudes. Students are selected on the basis of their interest in gaining insights into community health problems and their previous participation in community involvement projects. As a result, previous research has been unable to discern whether students are converted to liberal views as a result of project participation or whether the summer simply reinforces liberal attitudes previously established.

Consequently before measuring student attitudes on more specific issues such as comprehensive medical care and socialized medicine, a technique for learning an individual's degree of liberalism and conservatism was employed. Milton Rokeach has devoted a considerable amount of his career to the measurement of belief systems. This research utilized Rokeach's Opinionation Scale, 40 item test, designed to uncover an individual's degree of left opinionation, right opinionation, total opinionation and conservatism/liberalism.[11] Rokeach claims that the Opinionation Scale is meant to measure "general intolerance". It consists of a series of 20 statements prejudged to be leftist in orientation politically and 20 statements indicating a rightist political position. Within each of these two positions are 10 questions indicating either an acceptance or a rejection of the particular political stance. The Rokeach Opinionation Scale appears in appendix 2.

Total opinionation indicates how strongly an individual responds to both political positions combined. Left opinionation is the degree to which an individual accepts those statements indicating a left orientation. Right opinionation is the strength of agreement with statements associated with rightist political views. Liberalism/Conservatism is the difference between right opinionation and left opinionation; a positive score indicating conservatism, a negative score indicating liberalism.

Although Rokeach's scale is undoubtedly filled with flaws, and dated, if not questionable, content, it is the most highly researched attitudinal scale of this nature available, and by all indications the most accurate. There has been a great body of research to test its validity and reliability. For these reasons it was selected in this research. (For a further discussion of this scale see pp. 105-106 of this report.)

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[11] Rokeach, Milton, *The Open and The Closed Mind*. (New York, Basic Books, Inc., 1960.) Pp. 80-97.

In the experimental study (pp. 106-108) one can compare the political stance of PSHO medical students with Penn medical students who attended school during the summer. As noted there, PSHO medical students are significantly more left in orientation than are medical students who attended school.

The mean score for the subsample of PSHO medical students is almost identical to the mean score for all student participants. The subsample had an average left opinionation score of 84.2, while all students scored 84.7. The Penn medical students were not as far left in opinionation, scoring 72.81. Rokeach has also administered this scale to groups of students: in 1955, 186 Michigan State University undergraduates had an average left opinionation score of 61.2.[12] The comparison of PSHO participants with the Michigan sample reveals that PSHO was considerably more left in orientation. Also, however, the Penn medical students had a more leftist opinionation than the Michigan students. Table 14 below, shows the various sample scores on left opinionation. The higher the score, the more left opinionation.

Table 14.–Left and Right Opinionation of Students.

	N	X	SD	t	p	X	SD	t	p
PSHO students	60	84.7	20.03			63.8	10.0		
Michigan State	186	61.2	11.9	8.4	0.0005	80.8	11.9		
Difference		23.5		3.5	0.0005	17.0		10.8	0.0005
PSHO medical students	39	84.2	16.9			62.8	12.5	1.82	0.05
Penn Medical students	36	72.8	10.1			68.8	12.0		
Difference		11.4				6.0			

In terms of right opinionation, PSHO students in general during the initial orientation were less right oriented than Rokeach's sample, and the subsample of SHO medical students less right than Penn medical students. Table 14 above shows the sample scores on right opinionation. The higher the score the more right the opinionation.

In general, the PSHO students have a significantly greater left orientation than students sampled by Rokeach and a sample of medical students attending school.

The difference between the right and left opinionation results is a measure of liberalism-conservatism. PSHO students average score on this index placed them in a liberal position. There are no Rokeach scores with which to compare PSHO students on this dimension. However, the reader is again referred to the section concerning a comparison of PSHO medical students with Penn medical students. There it is shown that PSHO medical students are significantly more liberal than the Penn medical students who were sampled. Since PSHO students average liberalism scores are very similar to that of the PSHO medical student subsample, one would be led to believe that PSHO students on the whole came to the project with a tendency toward liberalism greater than that of students in general. Therefore, it would seem likely that PSHO health science students would tend to come to the projects predisposed to favor certain liberal attitudes.

Attitude Change

The data above tends to indicate that PSHO participants in general have liberal attitudes. Thus, the PSHO project, rather than an agent to convert conservative students to liberals, would appear to be geared toward carrying liberal attitudes to more liberal positions, or at least reaffirming liberal positions already held. At the beginning of the summer only 11 students (18 percent) held a conservative view and the majority of these were very mildly conservative. At the close of the summer, seven or 11.6 percent still held conservative views so that, at most, only four students moved from a conservative to a liberal position.

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[12] Rokeach, *op. cit.*, p. 95.

Tables 15, 16, 17, and 18 compare students' and staff's scores both before and after the summer experience on left opinionation, right opinionation, total opinionation and liberalism/conservatism. In each case, a higher score means a greater acceptance of the attitude in question. On the left and right opinionation scales scores can range from 20 to 140; on total opinionation, from 40-200; and on liberalism/conservatism, from ±1 to ±140. As can be seen from a glance at all tables, there was apparently a change only in right opinion among the students. That is, students did not become more left in opinionation (table 15), but less right (table 16). This, however, did not significantly affect their general scores on liberalism. The staff as well became less right and this change was sufficiently large to affect liberalism scores; therefore, staff members apparently became less right in opinionation and also moderately more liberal. Total opinionation, that is, how emphatically students reject one political stand and accept the other, or in this case the degree of leftism, remained constant from pre-test to post-test.

In terms of liberalism there was no significant change in attitude; students maintained approximately the same degree of liberalism from pre-test to post-test. The staff on the whole moved considerably more to the left; in fact, their average liberalism score more than doubled over the course of the summer.

On the whole, however, there was little change in the ideological position among the student participants in PSHO. This finding would tend to support the assertion that the experiences operate to reinforce opinions and beliefs already held and does not result in significant attitudinal shifts.

Table 15.–Left Opinionation of Students and Staff.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	84.67	20.03	0.66	N.S.	86.38	16.53	0.59	N.S.
After	87.00	18.34			91.88	18.04		
Difference	2.33	−1.69			5.50	1.51		

Table 16.–Right Opinionation of Students and Staff.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	63.83	10.02	3.19	0.005	70.13	0.025	2.25	0.025
After	57.83	10.44			54.12	9.20		
Difference	−6.00	.42			−16.01	−7.27		

Table 17.–Total Opinionation of Students and Staff.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	143.83	17.76	0.08	N.S.	155.25	23.58	0.84	N.S.
After	144.08	17.67			146.00	17.46		
Difference	.25	−.09			−9.25	−6.12		

Table 18.–Liberalism of Students and Staff.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	23.33	24.84	0.26	N.S.	16.38	16.92	2.03	0.025
After	24.51	24.51			37.75	22.12		
Difference	1.18	−.33			21.67	5.20		

Medical Attitudes: Since the majority of the students were pursuing careers in the field of health science, the research was interested in learning whether there were changes in medical attitudes over the course of the summer. Considerable research was conducted by the University of Colorado School of Medicine in the 1950's when they introduced a physician's educational program which emphasized comprehensive medical care. That research compared two groups, one exposed to a traditional educational program and the other exposed to the innovative comprehensive care program.[13] In an attempt to evaluate the newer and broader program's effect on medical students' training, the researchers used Boswell and Newman's "Medical Attitudes Test. Since the purpose of the comprehensive coursework at Colorado was much like the purpose of PSHO, that is, cultivating a broader approach to treatment rather than concern with the narrow organic disorder, interest in the prevention of disease rather than the curative process only, and the development of a multidisciplinary approach in medical treatment, it was an excellent model for the present research. Three of the five scales in Boswell and Newman instrument were used: (a) Attitude toward comprehensive medical care; (b) attitude toward the team approach in medicine; and (c) attitude toward preventive medicine. The three scales in combination are compiled as a total medical attitude scale. A brief description of each of the scales is given below along with the results of the pre- and post-test administration to the PSHO students.

Comprehensive Care: This scale measures a subject's attitude as a physician toward taking responsibility for the patient's total health, the general health of other family members, and the environmental and social factors which enter into an individual's health status. The before and after results on this scale for both the staff and student workers is presented in table 19 below. Scores can range from 1 to 50; the higher the score, the more favorable the attitude toward comprehensive care.

Table 19.–Attitude of Students and Staff Toward Comprehensive Medical Care.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	36.97	3.62	0.09	N.S.	40.38	2.74	1.00	N.S.
After	37.03	3.56			41.75	2.16		
Difference	.06	—.06			1.37	—.58		

The table shows that students' and Staff's attitudes did not become more favorably disposed toward comprehensive medical care but remained remarkably constant from pre-test to post-test.

Team Approach: This scale measures the subject's opinion concerning the value of consulting and working with other nonmedical professionals and such as social worker, psychologists, and the benefit of a team consultation among all treatment personnel such as technician, therapist and nurse. Table 20 reflects the test results on this attitude scale.

Table 20.–Attitude of Students and Staff Toward the Team Approach in Medicine.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	37.30	4.29	1.10	N.S.	40.13	2.93	2.01	0.025
After	36.50	3.56			36.25	4.18		
Difference	—.80	—.73			—3.88	1.25		

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[13] Kenneth R. Hammond and Fred Kern, *Teaching Comprehensive Medical Care* (Cambridge, Mass.: Harvard Univ. Press 1959.)

Table 21.–Attitude of Students and Staff Toward Preventive Medicine.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	39.13	4.82	0.11	N.S.	41.38	2.12	0.72	N.S.
After	39.23	4.32			39.60	6.22		
Difference	.10	.00			−1.78	4.10		

This table shows that the staff became significantly less in favor of a multidisciplinary approach to medical treatment over the course of the summer. If this finding is not spurious, one would be led to interpret that the interaction of staff with persons of other disciplines and in many different roles, resulted in a decline in proteam approach in medicine. As for students in general, there was no attitude change on this scale whatsoever.

Preventive Medicine: This scale measures opinion concerning the need for and importance of preventive medicine as opposed to a concentration on curative medicine alone. Table 21 contains the results on this scale.

There was no attitude change for the students on this measure; however, the average staff score was less in the post-test than in the pre-test. The difference between the two is not sufficiently large to indicate anything more than random variation, however.

Total Medical Attitude: This is a combination of all three scales and is an indication of an individual's overall opinion on these three medical issues in general. There is no significant change either for students or for staff as the following table summarizes.

Table 22.–Total Medical Attitude of Students and Staff.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	114.17	8.60	0.45	N.S.	121.88	4.31	1.13	N.S.
After	113.42	9.64			117.13	10.46		
Difference	−.75	1.04			−4.75	6.15		

In summary, the findings in regard to attitude toward various medical issues for students indicate that there was no change over the length of the summer. As for staff, the one change was a shift from a more favorable to a less favorable view of the team approach in medicine. To be noted too was the downward shift, although not statistically significant, the attitude toward preventive medicine and in total medical attitude for the staff.

Socialized Medicine: Another attitudinal scale administered to students concerned their opinion on the issue of socialized medicine. The scale was developed by R. A. Mahler in 1953 and is reproduced in Shaw and Wright's Scales for the *Measurement of Attitudes.*[14] In the original scale Mahler used the terms "compulsory health program" and "compulsory health insurance" to refer to a medical system supervised by the Federal government. In this research these terms were replaced by the phrase "socialized medicine" to avoid confusion and ambiguity.

Both among the staff members and the PSHO students there was a more favorable view of socialized medicine after the summer work experience, although the significance level in both cases leaves open to doubt the possibility that this change occurred by chance. The findings for socialized medicine are reflected in the Table below. Here the higher the score the more favorable the attitude toward socialized medicine.

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[14] Marvin E. Shaw and Jack M. Wright, *Scales for the Measurement of Attitudes.* (New York: McGraw-Hill Book Co., 1967) pp. 152-154.

Table 23.—Attitude of Students and Staff Toward Socialized Medicine.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	50.17	17.93	1.55	0.10	49.25	8.50	1.39	0.10
After	54.83	14.53			55.38	7.97		
Difference	4.66	−3.39			6.13	−.53		

Attitude Toward the Poor: A great number of the site assignments were to indigenous community organizations or to health and welfare institutions which serve the citizens of impoverished neighborhoods. Consequently, it was felt appropriate to discover whether student opinions about the poor were altered significantly as a result of their contact with the urban poor. The researchers were dissatisfied with the types of tests already available to measure individual's opinions about the poor. As a result a Likert scale, the "Philadelphia Student Health Organization Opinions About the Poor" test was constructed. There are 70 questions derived primarily from the works of Miller and Riessman [15] and Lewis.[16] Miller and Riessman in their article describe the life style of the working class in the United States. It includes working class attitudes toward the family, children, employment, politics, education and numerous other issues. Lewis, on the other hand, describes the lower class subculture of Puerto Ricans both in San Juan and in New York City. Both of these sources were used to obtain statements that might be true or not true of the urban poor in the United States. The research here is not concerned with whether Riessman and Lewis' statements about the social classes are accurate or not, but only whether students agree or disagree with the assertions made by the two authors after having been exposed to the poor. It was assumed that students would become more familiar with this group's qualities and, thereby gain sufficient firsthand knowledge to reject or accept the statements more decidedly. Any change in attitude assumedly would be based on actual field experience. Thirty-eight of the questions are drawn from the Riessman reference, 28 from Lewis and the remaining four from other sources. They primarily deal with factual matters which could be empirically verified such as the amount of illegitimacy and family conflict, nature of political opinion and the economic outlook of indigent persons generally.

This instrument must be viewed as completely exploratory at this point. No work has been done here to test its reliability and validity although this may be forthcoming.

Student attitudes toward the poor did change significantly over the course of the summer as table 24 indicates. Staff attitudes were not significantly different. However, this would be expected since the staff was mainly concerned with administrative matters which provided little contact with the urban poor. In this table, the higher the value the more agreement the students have with the Riessman & Miller descriptions.

Table 24.—Opinion of Student and Staff About the Poor.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	327.83	21.76	2.40	0.01	331.25	22.33	0.52	N.S.
After	338.00	24.24			339.13	33.00		
Difference	10.17	2.38			7.88	10.67		

Segregation: Since many of the students would be working in black ghettos and generally coming into closer contact with black citizens than had been their custom in the past, a test in attitude change in terms of racial prejudice was deemed appropriate. Quite an extensive search of the literature for attitudes toward Negroes was made. Most of the scales encountered were far too simplistic to measure subtle, unacknowledged prejudice that might be held among educated white students. No completely satisfactory measure was located, but among the most sophisticated appeared to be Rosenbaum and Zimmerman's "Attitude Toward Segregation Scale."[17] This is a 25-item scale which asks respondents for their feelings about racial integration of schools. Table 25 below reflects the before and after responses to the issue. The higher the score, the more prointegration the response.

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[15] S. M. Miller and Frank Riessman, "The Working Class Subculture: A New View," *Social Problems*, 9 (Summer 61), pp. 86-97.

[16] Oscar Lewis, *La Vida* (New York: Random House, 1954).

Table 25.–Attitude of Students and Staff Toward Segregation.

	Students				Staff			
	X	SD	t	p	X	SD	t	p
Before	122.08	11.47	0.79	N.S.	118.88	6.77	0	N.S.
After	120.33	12.69			118.88	9.03		
Difference	−1.75	1.22			0.00	2.26		

There was no significant change in attitude toward segregation either by the staff or by the students.

Involvement and Attitude Change: One possible reason for the absence of attitude change might be the assertion that attitude change occurred only among students who became deeply involved in the summer project and attitudes remained relatively constant for those who were uninvolved. In order to test this hypothesis, that attitude change depends upon degree of involvement, the research has correlated these two factors.

On the whole, attitude change is not related to involvement, except for two instances. In these two cases, however, the attitude becomes less favorable among the involved and more favorable among the uninvolved. The following paragraphs explain these findings.

In the questionnaire of the closing conference, students were given a list of PSHO activities, such as lectures, work-groups, conferences, social outings and weekly meetings (see app. 2). They were asked to check which of these they participated in or attended. From this list was constructed an index of involvement, the greater the number of activities in which one participated the greater the involvement. The possible range extends from participation in no activities to 19 activities. The actual range was participation in one, to participation in 19 activities. In the date presented below, involvement has been defined as participation in five activities, or more, and uninvolvement in four or fewer activities. While for the most part this decision is arbitrary, a review of the students and their involvement scores indicates from personal experience, that this is not an unreasonable point at which to draw the demarcation line between involvement and uninvolvement.

The contingency tables in which a significant relationship exists between involvement and attitude change are presented below.

Table 26.–Student Involvement and Opinionation.

Opinionation	Involved	Uninvolved
Increased right opinionation	23	16
Increased left opinionation	6	14
Total	29	30

X = 4.44, O = 0.27, p = 0.05.

Table 27.–Student Involvement and Opinions About the Poor.

Opinions about Poor	Involvement	Uninvolvemene
More empathic	14	25
Less empathic	15	5
Total	29	30

X = 11.9, O = 0.45, p = 0.001.

In these two cases, there is an association between involvement and attitude change, but in both cases those involved reflected attitude changes in a direction opposite that expected by the project. That is, the involved moved more to a rightist and the uninvolved to a leftist orientation politically and the involved to a less emphatic and the uninvolved to a more emphatic orientation toward the poor.

There is no significant association between involvement and attitude toward comprehensive medical care, total medical attitudes, liberalism, socialized medicine and attitude toward integration.

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[17] Marvin E. Shaw and Jack M. Weight, *Scales for the Measurement of Attitudes*, op. cit., pp. 168-177.

The surprising finding then is that, while for the most part there is no contingency between attitude change and project involvement, where such a contingency exists, it is antithetical to the project's intentions.

A note of caution should be interjected, however, concerning the relationship between opinions about the poor and involvement. It is quite possible that those who came into intimate contact with the poor learned that one cannot make sweeping generalizations about the poor and consequently lowered their score on this scale of indicating uncertainty or making agreement or disagreement with less definitiveness than initially. As mentioned previously, this is the first usage of this scale, and until it has been validated, the test results remain open to question.

Conclusion: The results of the administration of a total of eleven attitudinal scales gives evidence of change only on two of these for students (right opinionation and opinions about the poor) and on four for the staff (team approach in medical treatment, right opinionation, liberalism and possible socialized medicine). Testing whether the lack of change is a result of noninvolvement in the project reveals that involvement and attitudinal change are not generally related, except in two cases where the noninvolved had significantly more positive changes in attitude than the involved.

Student Accomplishments and Student Perceptions of PSHO

Student Accomplishment: Very little of the research effort has been devoted to evaluating the impact of PSHO on the community or on institutions in which students were placed. While highly desirous of obtaining information about specific accomplishments, it is practically impossible to measure the collective influence of 80 health science students dispersed throughout a city of 2 million people. Information in other sections of the report reveals in descriptive fashion the efforts and attainments of specific projects. Here mention can only be made to several minor indices of accomplishment.

Continuity of Projects: Twenty-seven percent of the students indicated they planned to continue to work in the ensuing year with the community organization or the institution with which they were placed, 56 percent had no such plans, and 16 percent were uncertain.

Curricula Reform: Thirty-nine percent indicated that they had specific plans for attempting curricula reform or faculty education in their professional school in the following academic year, 27 percent were uncertain, and 30 percent had no definite plans.

Poverty Practice: At the close of the summer, 22 percent had plans to eventually practice their profession in a poverty area, 61 percent were undecided and 17 percent did not have such plans.

Council in Medicine: During the course of the summer, 26 students counseled 87 individuals about a career in medicine. No effort was made in the research to elicit in what depth this counseling took place, nor whether some individuals, particularly the youth interns, were the recipients of multicounseling.

Active Reform: Students were asked if as a result of their participation in PSHO, they had become active and 59 percent were not.

The section on problem papers by Miss Lynch reflects a great deal of information relevant to the perceptions of PSHO. Only a few items on this topic were covered by the questionnaire method. In general, however, it appears that there is a considerable discrepancy between what students expected to accomplish and what they felt actually was accomplished. This discrepancy holds true both at the individual level and for PSHO as an organization. Students were asked at the opening orientation "how effective do you think your summer activities will be in improving the conditions of the poor.: At the closing conference the same question was repeated with only a change in wording, that is, "How effective do you think your activities *were* . . . " Results on the pre-and post-question show a sharp decline in estimated effectiveness. Originally, almost all students felt that they as individuals would be to varying degrees effective, and only 5 percent thought they would have no effect. However, by the closing conference, over 50 percent thought they personally had no effect and only 33 percent thought they had been to some extent effective. Moreover, only one individual originally thought he personally might be ineffective; nine individuals felt this way at the close of the summer. In general terms then, there was a considerable downward shift in effectiveness judged by students from the beginning to the end of the summer. Table 28 reflects these facts.

Table 28.–Judgment of Students and Staff as to Individual Effectiveness in Improving Conditions of Poor, Before and After.

Degree of effectiveness	Students (percent)		Staff (percent)	
	Before	After	Before	After
Exertmely effective	1.6	....	....	....
Very effective	1.6	....	....	....
Moderately effective	30.6	8.3	....	12.5
Slightly effective	59.7	25.4	25.0	....
No effect	4.8	50.8	50.0	62.5
Slightly ineffective	....	1.7	....	....
Moderately ineffective	1.6	3.4	....	....
Very effective	....	5.1	....	....
Extremely ineffective	....	5.1	25.0	12.5
Total	99.9	99.8	100.0	100.0

N Students before = 62.
N Students after = 59.
N Staff = 8.
$X^2 = 48.9$; df = 8; $p = 0.001$.

Students and staff were also asked both at the orientation and final conference "how effective do you think the PSHO project as a whole will be (was) in improving conditions of the poor." There was here also a significant decrease in students judgment of organizational effectiveness. At the outset, over 90 percent felt the organization would be effective to some extent, whereas in the end this had decreased to about 53 percent. Only one individual judged the project would be ineffective during orientation, but 13 held this judgment at the final convocation. Data on this question are shown in table 29.

Table 29.–Judgment of Students and Staff as to Effectivetiveness of PSHO in Improving the Conditions of the Poor, Before and After.

Degree of effectiveness	Students (percent)		Staff (percent)	
	Before	After	Before	After
Extremely effective	1.6	....	....	....
Very effective	1.6	....	....	....
Moderately effective	38.7	3.4	12.5	....
Slightly effective	50.0	49.2	50.0	25.0
No effect	6.5	25.4	25.0	75.0
Slightly ineffective	1.6	6.8	....	....
Moderately ineffective	1.6	5.1	....	....
Very ineffective	....	6.8	....	....
Extremely ineffective	....	3.4	12.5	....
Total	100.0	100.1	100.0	....

Students $X^2 = 33.9$; df = 8; $p = 0.001$ (N's = Same as table 28).

In an effort to determine what might be the source of dissatisfaction, an open-ended question at the close of the projects asked "what major problem if any, do you see with the internal organization of PSHO." Below are the classified results.

Table 30.–Judgment of Students on Major Internal Problems of PSHO

	Percent
Lack of formal organization	25.4
Lack of clear-cut goals	15.3
Lack of leadership	13.6
Lack of communication	5.1
Overly theoretical	5.1
Inadequate site development	5.1
Inadequate area coordination	3.4
Absence of community personnel on staff	3.4
Inadequate preceptors	1.7
Inadequate representation of nonmedical students	1.7
Inadequate office management	1.7
No answer—none	18.6
Total	100.1

N = 59.

Students were asked at the final session to indicate how satisfied they felt in general about their role in PSHO. In table 31 below, one can see that 58 percent indicated that they were very or somewhat satisfied and 32 percent were very or somewhat dissatisfied.

Table 31.–Satisfaction of Staff and Students With Role in PSHO.

	Students (percent)	Staff (percent)
Very satisfied	15.3	12.5
Somewhat satisfied	42.4	50.0
Uncertain	10.2	....
Somewhat dissatisfied	25.4	37.5
Very dissatisfied	6.8	....
Total	100.1	100.0

Student N = 59. Staff N = 8.

While it seems probable that there would always be a percentage of student discontent with their position no matter what its nature, the fact that one-third of the students indicate dissatisfaction and another 10 percent uncertainty may be disproportionate. Also, only 15 percent responded as being "very satisfied."

From this tabulation it would seem that the administration of the project in the eyes of the students was lacking. The lack of formal organization, goals and leadership all involve the basic structure of the organization. As mentioned earlier, however, the project was intentionally designed to be decentralized in order that students themselves might establish their own goals on an individual basis rather than be handed guidelines and directions from a central authority. These findings might show that students were displeased with an unstructured program and would be desirous of more direction and formal organization. In any case, it should be made explicit that student dissatisfaction may result from other sources in addition to the internal organization, and in fact, this conceivably may not be the primary source of dissatisfaction.

Finally, students were asked if they would participate in PSHO if it were repeated in the future: 32 percent stated that they would, 22 percent that they would not, and 46 percent were uncertain.

It is impossible to make any definitive statements about student perceptions of PSHO; however, it would seem reasonable that students were somewhat less than enthusiastic about the summer project. There appears to have been a decided change in their anticipated effectiveness both individually and organizationally, two out of five were uncertain about or dissatisfied with their role, and only three out of ten were readily willing to reparticipate in a future project.

Penn Medical Student and PSHO Medical Student Comparison

Introduction

This report compares the attitudes of medical students who attended school during the summer with those of medical students participating in PSHO. Within PSHO there were initially 3 individuals, both male and female, attending medical schools. The remaining 35 PSHO participants were students of numerous other disciplines ranging from nursing and dentistry to social work and law. This report compares the 39 PSHO medical students with a group of nonparticipating medical students who were actually attending medical school during the summer.

The Problem:

PSHO research in the past has been interested in learning what effect actual participation in community work projects has on both the medical and social attitudes of the project workers. It attempted to learn whether this experience is successful in provoking attitude change. This previous PSHO research, however, has been beset by two major limitations: (a) the absence of a control group by which comparison in attitude change might be made, and (b) the inability to determine how strongly student participants identified with the attitudes in question prior to their participation. The small experimental comparison reported here has attempted to correct these limitations. Herein is presented a comparison of second year medical students both before and after the summer with the medical student participants of PSHO at the same time periods.

Methodology:

The Dean of the medical school of the University of Pennsylvania permitted the researchers to record the names and addresses of 61 second-year medical students attending classes and working in hospitals during the summer. The same questionnaire given to PSHO medical students during orientation was mailed to Penn students during the first week of the project. The questionnaire was coded for anonymous replies and contained background data questions and four attitudinal tests: attitudes towards the poor, socialized medicine, general medical attitudes, and the Rokeach opinionation scale. The entire instrument required approximately one hour to complete. Most of these students were telephoned in advance and informed that they had been selected as a member of the control group and that a questionnaire addressed to them was being placed in the mail. No student objected to receiving the questionnaire.

Originally, the researchers wanted to compensate the Penn students for their effort and funds that could be devoted to this purpose were available. It was known that medical students were exceptionally busy, both attending courses and working long hours, often at night, and consequently seldom had free time. Some monetary compensation for the time required to fill out the questionnaire, it was felt, might insure a larger and more adequate return, particularly since the researchers were asking for a return at two different times of which the absence of either would make the participants' results unusable. Members of the medical profession, however, counseleed that payment would be "unethical." They suggested that most medical students would be willing to contribute to a research project voluntarily since it concerned their profession—students would be willing to participate freely as fellows in the medical community. This was not completely the case.

Of the 61 questionnaires mailed to the students, three were undeliverable by the post office and 38 were completed and returned at the start of the summer. This is a return rate of 67 percent. As for the post-test mailing which began when the projects closed in late August 1968, only 32 or 54 percent of the total students fully cooperated with the research effort by returning completed questionnaires. When contacted by telephone, most of those who did not cooperate explained that they were simply far too busy to devote time to the research. A few other students reacted vehemently to the content of the questionnaire, however, claiming that it was highly biased.

The content of the questionnaire, actually, was determined by the nature of the PSHO project, that is, the attitude scales were those relevant to the attitudes PSHO was interested in changing. They were selected on the basis of the goals PSHO was attempting to attain. There was no implicit interest by the researchers in demonstrating that PSHO students were in any way superior to medical students attending school. While no social science research is ever successful in being completely value free, the research was not out to prove that PSHO participants were the socially concerned reformers and the medical students attending school, the unconcerned conservatives. The research simply required a base group by which comparisons in attitude shifts could be made, and the Penn medical students were a convenient and available group.

A major criticism by the Penn students centered around the Rokeach Opinionation Scale (see app. 3 and pp. 95-96). This scale attempts to measure an individual's political position by asking for agreement or disagreement with brief, opinioned statements. The statements admittedly are dated, concerning political issues and personalities no longer contemporary, and the items are so blunt and naive as to be an insult when answered by intelligent, sensitive individuals.

This test, although certainly filled with flaws, is designed to uncover how intolerant an individual is of opposing points of view and how dogmatically he accepts his own view. Failing to agree strongly with one's own position and failing to reject strongly alternative positions theoretically gives evidence of one's tolerance level. At the same time the mild acceptance reveals one's political stance. The Rokeach instrument unquestionably requires refinement and greater sophistication. In the interest of overcoming the limitations of previous studies, namely the inability to know the ideological position of PSHO students prior to the entry in the project, the Rokeach scale was used. Its validity and reliability have been heavily researched both in this country and abroad. Until an improved scale is developed, the Rokeach scale will probably continue to be used with apologies.

Had the researchers been able to plan sufficiently in advance, a matched control group would have been selected. Not only a lack of time, but other difficulties as well, prevented this possibility. For example, we did not know some of the characteristics of PSHO participants until after orientation in June 1968. Application forms do not ask for characteristics such as race and religion, two attitudes which should be controlled in an experiment of this nature. Secondly, a delay by the medical school in granting permission to review student characteristics to choose matched pairs, even on attributes such as sex and age, precluded a matched control group. In fact, the use of the term "control group" is dubious. Actually, this report simply draws a comparison between medical students in school and medical students in PSHO. A full report is provided below as to what changes in attitude occurred among PSHO medical students compared with the Penn medical students, the difference in attitudes between the two groups and, finally, a comparison of the social background features of both groups.

The samples are small and the returns by Penn medical students limited, so that the research should be viewed as an exploratory attempt to extend PSHO research with the hope that future projects of this nature might come to more decisive findings.

Findings:

The findings are generally that little attitudinal change occurred among PSHO students from pre-test to post-test, but that there were strong distinctions between the two groups at both time periods.

Ideology:

The results indicate that the PSHO medical students did not alter their political attitudes as a result of the summer experience. On the left opinionation portion of the Rokeach scale, the PSHO medical students maintained almost identical average scores from pre-test to post-test. Penn medical students' attitudes also remained constant over the summer. There was, however, a significant difference between the two groups at both time periods, PSHO tending to be more leftist in outlook. Table 32 below describes the before and after results on this scale. The higher the score, the more left the opinionation.

Table 32.–Mean Left Opinionation Scores, PSHO and Penn Medical Students.

	PSHO medical		PSHO medical				
	X	N	X	N	Difference	t	p
Before	84.2	39	72.8	36	11.4	3.5	0.0005
After	84.6	36	72.5	30	12.1	3.8	0.0005
Difference	.4		–.3				
t	.11		.14				
p	N.S.		N.S.				

One tail test.

On the right opinionation scale PSHO medical students tended to become less and Penn medical students more, rightist in orientation over the summer. In the pre-test the difference in scores between PSHO and Penn medical students was 5.4 (p=0.05) while at the close of the summer the difference had increased to 13.8 (p=0.0005). It is then open to question as to whether the PSHO project is necessarily effecting attitude change. Quite possibly, national and international events, particularly in an election year, could be influencing student scores. Whatever the source, however, both groups appear to have changed position during the summer months. Table 33, below, reflects these findings.

Table 33.–Mean Right Opinionation Scores, PSHO and Penn Medical Students.

	PSHO medical		Penn medical				
	X	N	X	N	Difference	t	p
Before	62.8	39	68.2	36	5.4	1.8	0.05
After	59.1	38	72.8	30	13.8	4.7	.0005
Difference	–3.7		4.6				
t	1.4		1.4				
p	.10		.10				

One tail test.

Neither group reflected a change in Total Opinionation, that is, the combination of right and left opinionation, over the course of the summer. However, in the pre-test, PSHO students were significantly more opinionated than the Penn students although this difference decreased in the post-test in which both scored at approximately the same level.

The right and left opinionation scores can be used to measure liberalism and conservatism, by subtracting right from left opinionation. Scoring high on right and low on left measures a conservative political orientation, while scoring high on left and low on right indicates liberalism.

PSHO students did not become more liberal as a result of participation. Although the scores move in this direction, they are not sufficiently large to indicate more than chance variation.

The Penn medical students in the pre-test scored slightly liberal and in the post-test less liberal, although here too the difference may be due to chance variation in scoring. The combination of these slight movements, however, adds up to large differences between the two groups. While the difference between the two at the beginning of the summer was 14.5 (p=0.01), it increased greatly by the end to 26.4 (p=0.0005). This is similar to the findings on the right opinionation: the two groups moved in contrary directions which leads the post-test results to show far greater differences than the pre-test. Here also it would be difficult to assume that PSHO is the agent responsible for the attitude change. Had the Penn students score remained approximately the same, while only PSHO students scores changed, then there would be reason to contend that the PSHO experience induced the change. The trend of Penn medical students "downward" and PSHO students "upward" may reflect the trend in the United States generally toward a "polarization" of liberal and conservative attitudes. Table 34 summarizes the findings on liberalism; the higher the score the more liberal the attitude.

Table 34.—Mean Liberalism Scores, PSHO and Penn Medical Students.

	PSHO		Penn medical				
	X	N	X	N	Difference	t	p
Before	21.7	39	7.2	36	14.5	2.6	0.01
After	28.4	38	2.0	30	26.4	4.8	.0005
Difference	6.7		−5.2				
t	1.2		1.0				
p	N.S.		N.S.				

One tail test.

Medical Attitudes:

Both groups completed two sets of questions concerned with attitudes within the field of medicine. A more elaborate explanation of the content of these atttiude scales can be found on pp 287. One was Boswell & Newman's "Medical Attitudes Test" consisting of three subscales: attitude toward comprehensive medical care, attitude toward the team approach in medicine, and attitude toward preventive medicine. The second was Mahler's "Socialized Medicine Attitude Scale" (see app. 3, pts. II and V).

Comprehensive Care:

This scale concerns attitudes toward regarding a patient's total health as within the physician's purview, the willingness to assume responsibility for additional family members health care needs, and concern with social and environmental conditions which might influence health status.

PSHO students did not alter their attitude on this dimension. In regard to the differences between the two groups, initially PSHO had a significantly higher average score in favor of comprehensive care than Penn students; however, by August both groups average scores moved closer together, PSHO's slightly decreasing and Penn's slightly increasing so that no significant difference remained.

Team Approach:

Neither group's attitude toward the team approach in medicine, that is favoring the use of non-medical professionals such as psychologists and social workers and favoring conference-like discussions with medical specialists such as nurses and technicians in the treatment of a case, reflected a change over the summer.

However, PSHO students demonstrate a more favorable attitude on this measure than do the Penn medical students in the beginning of the summer, but not necessarily at its conclusion. The difference between the two groups initially was 2.8 (p=0.01) but only 1/5 (p=0.10) after. The average score for Penn slightly increased and the PSHO average slightly decreased thereby eliminating a significant difference in the post-test.

Preventive Medicine:

PSHO students' attitude toward the importance of preventive medicine as opposed to curative medicine did reflect a significant position change. Table 35 below indicates that Penn medical students average score remained relatively constant while that of PSHO students increased. In this table, the higher the score, the more favorable the attitude toward preventive medicine.

There was also a considerable difference between the two groups in both the pre- and post-test; PSHO in both cases evincing a higher preventive medicine score than Penn students.

Total Medical Attitude:

PSHO students' and Penn students' averages on a combination of all three measures reflects no changes from pre- to post-test. There is, however, a significant difference between the two groups at both stages of measurement. PSHO students score higher than Penn students both at the beginning ($t=9.7$, $p=0.0005$) and conclusion ($t=6.8$, $p=0.005$).

Table 35.–Mean Preventive Medicine Scores, PSHO and Penn Medical Students.

	PSHO medical		Penn medical				
	$\bar{X}$	N	$\bar{X}$	N	Difference	t	p
Before	36.3	39	32.4	38	3.9	3.6	0.0005
After	38.4	38	33.6	32	4.8	3.9	.0005
Difference	2.1		1.2				
t	2.1		1.0				
p	.025		N.S.				

One tail test.

Socialized Medicine:

This test measures to what degree an individual favors a health care system in the United States which is supervised by the Federal Government. The PSHO students' attitude in this area was more in favor of a federally regulated medical system at the end of the summer than at the beginning although the statistics indicate that possibly this change is due to random variation in responding to the questions rather than an actual change in attitude. Table 36 below shows the pre- and post-test results for PSHO students on this index.

Table 36.–Mean Socialized Medicine Scores, PSHO and Penn Medical Students.

	PSHO students		Penn students				
	$\bar{X}$	N	$\bar{X}$	N	Difference	t	p
Before	49.6	39	35.6	36	14.0	3.4	0.0005
After	55.0	38	35.3	31	19.7	5.4	0.0005
Difference	5.4		.3				
t	1.4		.05				
p	.10		N.S.				

One tail test.

This table also shows that PSHO students are far more inclined to favor socialized medicine than are Penn students.

Attitude Toward the Poor:

About two-thirds of the PSHO project sites were with community organizations in urban

Table 37.–Mean Opinions About the Poor Score, PSHO and Penn Medical Students.

	PSHO students		Penn students				
	X	N	X	N	Difference	t	p
Before	323.7	39	341.1	36	17.4	4.2	0.0005
After	333.4	38	327.3	31	6.1	1.2	0.10
Difference	9.7		−13.8				
t	1.9		3.3				
p	.025		.005				

One tail test.

slum areas and most of the remaining one-third were with official institutions serving such areas. Intimate exposure to the living conditions and problems of the poor were expected as a part of the summer activities. In order to find whether personal contact lead to changes in attitudes toward the poor, the research team developed a 70-item test (see pp. 100-101 and app. 3). It consists of statements to be accepted or rejected by the respondent concerning the political philosophy, family structure, economic views and other social matters, of the poor. The test was constructed hurriedly shortly before the summer project was launched in June 1968 and consequently no time was available to perform extensive pretesting, nor to establish its validity and reliability. The results show a great deal of attitudinal shifting both by Penn medical and PSHO medical students, so that its content needs to be very carefully investigated before it is used in the future. The basic problem is determining the scoring of the questions. For the present research they were scored when a subject indicated agreement with the two major scholars' monographs from which the questions are drawn (see p. 100). However, one scholar describes the working class, not the lower class, so that agreement with the items taken from his reference may not be accurate in regard to the lower class. If, for example some of these items apply exclusively to the working class, then answering in agreement with his assertions is inaccurate in regard to the lower class and the scoring would, therefore, need to be reversed. A second problem concerns the wisdom of generalizing about the poor. Although the test is designed for attitudes about the urban poor specifically, this population's characteristics undoubtedly varies according to rate and geographical region as well as other factors. It may be that intimate contact results in a lowering of overall score, since the respondent may come to feel that it is inappropriate to generalize widely about the poor after having personally observed their life conditions.

The researchers feel that the attitude toward the poor test developed by PSHO is an improvement over existing tests, but requires item analysis and additional study before it is adopted by future research projects.

The findings indicate that both groups changed attitudes toward the poor. These facts are illustrated in table 37 below. The higher the score, the more familiar with the circumstances of the poor.

The table reveals that PSHO students significantly increased scores while Penn students decreased in regard to the poor. While one might expect PSHO student scores to change as a result of exposure to indigent community life, the change by Penn students is not readily explicable.

Background Comparison:

As mentioned earlier in the research, a more structured research design would have required a matched control group for the experimental comparison. Time limitations prevented this possibility and, as a consequence, the researchers opted for what they hoped would be an acceptable matched group control. Thus, rather than matching pairs, it was hoped that the average background characteristics of the two groups would be sufficiently similar to allow group comparisons. What follows then is a description of the background differences of the two groups. The groups were, of course, similar in some traits on the average and considerably different in others.

Both groups consisted of 89 percent males, and approximately 95 percent of each group was white. However, the Penn medical students were on the average significantly older and had significantly different religious backgrounds. The average age of PSHO medical students was 22.9 years, whereas the Penn students were slightly over 24 years of age. (This difference is statistically significant—X2=28.4; df=7, p=0.001.)

The two groups also differed significantly in terms of family religious background. Almost half of the PSHO medical students come from Jewish families, whereas more than half of the Penn students have a Protestant family religion. This data is shown in table 38 below.

Table 38.–Family Religion of PSHO and Penn Medical Students.

Religion	PSHO students		Penn students	
	Percent	N	Percent	N
Protestant	20.5	8	56.8	21
Catholic	17.9	7	21.6	8
Jewish	48.7	19	18.9	7
Other	12.7	5	...	0
Total	99.8	39	100.0	36

$X^2=15.8$, $df=3$, $p=0.01$.

In terms of social class, PSHO students and Penn students differ, but not significantly. Most students in both groups come mainly from the middle and upper classes (see p. XX for the method of determining social class). Table 39 gives the data on social class.

Table 39.–Social Class of PSHO and Penn Medical Students.

Social class	PSHO students		Penn students	
	Percent	N	Percent	N
Upper	38.5	15	35.1	13
Middle	38.5	15	56.8	21
Working	20.5	8	8.7	3
Lower	2.5	1	....	0
Total	100.0	39	100.0	37

$X^2=4.4$; $df=3$; $p=0.30$.

Family income of the parents of the two groups does not vary significantly although Penn students come from families that earn more money on the average. The mean income of Penn students' parents was $18,776 whereas PSHO was $16,664, a difference of over $2.000 annually. This does not amount to a statistically significant difference, however (X2=5.6, df=6, p=0.50).

In regard to educational experience which might have influenced the manner in which the two groups answered the questionnaire, Penn students in general had significantly more academic preparation by enrollment in courses concerning community medicine. Twenty-seven percent of the Penn, but only 8 percent of the PSHO students had coursework in this area. On the other hand, however, PSHO students had significantly more actual experience in community work. Over 38 percent of the PSHO students had previous participation in social action projects, whereas less than 11 percent of Penn medical students had this experience. Table 40 below reflects these differences between the two groups.

Table 40.–Community Medicine Coursework and Practical Experience of PSHO and Penn Students.

	Coursework				Experience			
	PSHO students		Penn students		PSHO students		Penn students	
	Percent	N	Percent	N	Percent	N	Percent	N
Yes	7.7	3	27.0	10	38.5	15	10.8	4
No	92.3	36	73.0	27	61.5	24	89.2	33
Total	100.0	39	100.0	37	100.0	39	100.0	37

$X^2=5.00$; $df=1$; $p=0.05$. $X^2=7.74$; $df=1$; $p=0.01$.

In summary, a comparison of the two groups shows that Penn medical students are significantly older, have had significantly more course work in community medicine and less practical experience in social action programs than PSHO medical students. In terms of other characteristics; sex, race, social class and family income, the two groups are essentially similar.

How much these background differences contribute to the differences in responses to the attitude scales is purely a matter for speculation. It is possible that age alone could account for the difference in answering. Therefore, we can only note the possibility that the summer experience is only one contributing factor to the differences in response to the questionnaire.

Conclusion:

There was no change in PSHO medical students attitudes from pre-test to post-test in terms of left opinionation, total opinionation, liberalism, comprehensive medical care, team approach in medicine, and medical attitudes in general. There is a possibility that PSHO students became less rightist in political ideology and more in favor of socialized medicine, but these changes may be due to random variation. The two measures on which there are definite, significant changes are: more favorable attitudes toward the poor and more favorable attitudes toward preventive medicine.

As for the Penn medical students, there was no change in left opinionation, total opinionation, liberalism, comprehensive care, team approach, preventive medicine, medical attitudes in general, and socialized medicine. There was possibly a more right-leaning political stance at the end of the summer, but here too the resulting difference may be simply scoring fluctuation. Penn medical students became significantly less favorably inclined toward the poor in the post-test.

As to the difference between the two groups, however, they are significant on all ten indexes in the pre-test and on six in the post-test. In cases where the difference dissipated over the summer, it is generally movement by both groups in the other group's direection. There is no way to determine why there was no distinction between PSHO and Penn students on comprehensive care, team approach, total opinionation, and attitudes toward the poor in the post-test as there was in the pre-test. Quite possibly events external to both groups were creating a stimulus for opinion change.

Since the ten attitude scales have differentiated between the two groups, particularly in the initial testing, one is tempted to think that the tests are relatively accurate and there exist other factors to account for the absence of more widespread attitudinal change within the PSHO student group. The most apparent reason would be the assertion that PSHO project on the whole is not a source of pervasive attitude change. This would be corroborated by the fact that there was little manifest attitudinal change among the total SHO participants (see pp. 95-101). Whether this is the case or not, remains open to question and debate. It should also be mentioned that the California 1966 research project, using a completely different set of attitude scales found a change only in attitudes toward the poor.[28]

It should be stipulated very clearly, however, that the absence of profound attitude change is possibly not a just reason to question the value of the total PSHO experience.

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[28] USC-SMC Student Health Project, op. cit., p. 17.

Section V

APPENDIXES

APPENDIX 1

Pre-Test Background Questionnaire
Philadelphia Student Health Organization

The following questionnaire consists of six parts. Please read the instructions to each part and answer each one carefully.

PART I: BIOGRAPHICAL DATA

1. Name
2. Home address
3. School address
4. Age
   (years) (months)
5. Field of Study
6. Undergraduate major
7. Race
8. Family religion
9. Family's annual income:
   up to $2,999
   $3,000 to $5,999
   $6,000 to $8,999
   $9,000 to $14,999
   $15,000 to $19,999
   $20,000 to $24,999
   over $25,000
10. Father's occupation:
    (be specific: if deceased or retired list former occupation)
11. Mother's occupation
12. Have you previously had any actual experience with social action programs in poverty areas such as SHO. If so please list locations and dates:
13. Have you ever had a course in comprehensive medical care or community medicine:
    yes no
14. Please rank in decreasing order of importance (from 1 to 5) your major reasons for participation in the Philadelphia SHO project for the summer:
    —the opportunity to learn about urban slum conditions firsthand.
    —the opportunity to live and work in Philadelphia.
    —the opportunity to help advance the civil rights movement.
    —the opportunity to earn $900.00.
    —the opportunity to associate with health science students.
    —the opportunity to learn about community medicine firsthand.
    —the opportunity to help the poor.
    —the opportunity to work with a practicing health professional.

—the opportunity to help bring about social change.
—others (please list).

15. Describe what you presently feel will be the biggest problem you face in carrying out your work activities this summer:
16. How effective do you think your summer activities will be in improving the conditions of the poor:
    Extremely effective
    Very effective
    Moderately effective
    Slightly effective
    No effect
    Slightly ineffective
    Moderately ineffective
    Very ineffective
    Extremely ineffective
17. How effective do you think the SHO project will be as a whole in improving the conditions of the poor:
    Extremely effective
    Very effective
    Moderately effective
    Slightly effective
    No effect
    Slightly ineffective
    Moderately ineffective
    Very ineffective
    Extremely ineffective
18. How much do you think your summer work experience will add to your professional education:
    A great deal
    Considerably
    Moderately
    Very little
    Nothing

APPENDIX 2

Post-Test Background Questionnaire
Philadelphia Student Health Organization

The following questionnaire consists of six parts. Please read the instructions to each part and answer each carefully.

PART I: EVALUATIONAL DATA

1. Name ____
2. How much do you think your work experience this summer has added to your professional education:
    __a great deal
    __considerably
    __moderately
    __very little
    __nothing
3. To what extent, if any, was the summer experience helpful in acquiring knowledge for your future career:
    __very helpful
    __moderately helpful
    __slightly helpful
    __not helpful at all
    __detrimental
4. To what extent, if any, was the summer experience helpful in acquiring specific skills for your future career.
    __very helpful
    __moderately helpful
    __slightly helpful
    __not helpful at all
    __detrimental

5. Which of the following type of school do you attend:
   ___professional
   ___graduate
   ___undergraduate
   ___technical
   ___other (specify) ____________________.

6. What was your grade point average (4 pt. system) for the last semester of school attended:
   ____

7. In terms of academic standing where do you rank:
   ___top 10 percent of class
   ___top 25 percent of class
   ___top 50 percent of class
   ___below the top 50 percent of class

8. Please rank in decreasing order of importance (from 1 to 5) your major reasons for participation in the PSHO project for the summer:
   —the opportunity to learn about urban slum conditions firsthand
   —the opportunity to live and work in Philadelphia
   —the opportunity to help advance the civil rights movement.
   —the opportunity to earn $900.00
   —the opportunity to associate with health science students.
   —the opportunity to learn about community medicine firsthand.
   —the opportunity to help the poor.
   —the opportunity to work with a practicing health professional.
   —the opportunity to help bring about social change.
   —other (please specify)

9. Please rank in decreasing order of importance (from 1 to 3) the major benefits as a result of participation in the PSHO project, if any:
   —the opportunity to learn about urban slum conditions firsthand.
   —the opportunity to live and work in Philadelphia.
   —the opportunity to help advance the civil rights movement.
   —the opportunity to earn $900.00
   —the opportunity to associate with health science students.
   —the opportunity to help the poor.
   —the opportunity to work with a practicing health professional.
   —the opportunity to help bring about social change.
   —the opportunity to learn about community medicine fiirsthand.
   —other (please specify)

10. Describe what you presently feel was the biggest problem you faced in carrying out your work activities this summer:

11. Did you live in the area in which you worked:
   ___yes, if yes was it a poverty area: ___yes
   ___no ___no

12. Did you attend the initial PSHO orientation session at Eagleville:
   ___yes
   ___no

13. Did you attend the PSHO picnic at Parvin State Park:
   ___yes
   ___no

14. Did you attend the PSHO midsummer conference at Eagleville:
   ___yes
   ___no

15. Please indicate how frequently, if at all, you attended the "Tuesday night group meetings:"
   ___regularly
   ___somewhat regularly
   ___irregularly
   ___not at all

16. Please indicate which of the following PSHO activities you attended or participated in, if any:
—Cherry's "The Jungle."
—Woodruff's "A Black Analysis of Our Society."
—Energies of Mantua
—Communities Relations and the Police.
—Rat Control and Health Problems in the Ghetto.
—First Aid Course.
—Friends Peace Committee Non-violent, Direct Action Course.
—Workgroup on Curricula Reform.
—Workgroup on Black Admissions.
—Workgroup on Education (Elaine Hagen's planning group).
—Workgroup on Communication & Publicity (Chip Smith & Joan Horan).
—Workgroup on Project Continuity (Ron Blum)
—Workgroup on the Newsletter (Dick Devereaux).
—Workgroup on Lucia's Play.
—Other (please specify).

17. Do you presently plan to practice your profession in a poverty area:
__yes
__no
__uncertain

18. Do you presently have any specific plans for attempting curricula reform or faculty education at your college in the fall:
__yes
__no
__uncertain

19. Do you presently have plans to continue to work in the fall with the community organization or institution with which you were placed this summer:
__yes
__no
__uncertain

20. Are you presently active in any group seeking social change as a result of your participation in the PSHO summer project.
—yes
—no

21. During your summer activities did you counsel anyone about a career in medicine:
__yes, if yes how many_____.
__no

22. How effective do you think your summer activities were in improving the conditions of the poor:
__extremely effective
—very effective
__moderately effective
__slightly effective
__no effect
__slightly ineffective
__moderately ineffective
__very ineffective
__extremely ineffective

23. How effective do you think the PSHO project was as a whole in improving the conditions of the poor:
__extremely effective
__very effective
__moderately effective
__slightly effective
__no effect
__slightly ineffective
__moderately ineffective
__very ineffective
__extremely ineffective

24. Indicate how you feel in general terms about your role in the Summer project:
__very satisfied
__somewhat satisfied
__uncertain
__somewhat dissatisfied
__very dissatisfied

25. Assuming that PSHO repeated its summer project in the future, would you participate:
__yes
__no
__uncertain

26. What major problem, if any, do you see with the internal organization of PSHO: (explain). Use the back of this page for other comments, criticism, observations, suggestions, etc.

APPENDIX 3

Attitude Scales

PART II: BOSWELL AND NEWMAN MAT

Instructions: This is a study of what medical students and people in general think about a number of social and medical questions. The best answer to each question below is your personal opinion. We have tried to cover many different points of view. You will find yourself strongly in favor of some and disagree strongly with others. For some statements your opinions will not be as clear cut. Whatever way you feel about any of the statements you can be certain that a good many people feel the way you do. Be sure to answer every item. After all, no knowledge, but only your opinion is involved. Think quickly: your immediate reaction to the statement is probably the best one.

Read each statement carefully. Below it are five possible answers numbered 1, 2, 3, 4, and 5. *Circle* the answer you think best represents the way you feel.

1. How important do you think it is for the doctor to know the effect of the patient's illness on his family in order to provide adequate treatment?
1. Not important at all
2. Pretty unimportant
3. Not so important
4. Pretty important
5. Very important

2. The greatest service a physician can provide is in following longterm health and adjustment of patients and families rather than in concentrating only on the treatment of immediate illness complaints of his patients.
1. Strongly disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

3. In medical practice today there are sufficient specialists so that a physician in general practice should not assume long-term responsibility for his patients.
1. Completely disagree
2. Disagree
3. undecided
4. Agree for the most part
5. Agree completely

4. The medical school should train students for specialties rather than general practice.
1. Disagree completely
2. Disagree
3. Undecided
4. Agree
5. Agree completely

5. Do you think that as a physician you would prefer to have for your patients all members of a family rather than patients as individuals?

1. Definitely not
2. No
3. Undecided
4. Yes
5. Definitely yes

6. The most important function of the physician is to immediately relieve the suffering of the patient.

1. Strongly disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

7. In a general practice there is no reason to stress good health and promote disease prevention since the average patient only wants to pay for the alleviation of his disease.

1. For practically no cases at all
2. For very few cases
3. For some cases
4. For most cases
5. For practically all cases

8. How practical do you think it is for a doctor in clinical practice to take time to follow up provocative clues other than the presenting symptoms?

1. It is always impractical
2. It is usually impractical
3. Undecided
4. It is usually practical
5. It is always practical

9. Do you think medical training in the clinical years should concentrate most of the student's time on evaluation and treatment of specific disease processes?

1. Definitely not
2. No
3. Undecided
4. Yes
5. Definitely yes

10. A specialist such as an otologist, gynecologist, psychiatrist, etc., generally would be less effective on a routine home call than a general practioner.

1. Strongly disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

11. Do you think that in a medical setting, the doctor should have all personnel involved in the treatment of patients participate in case discussions regardless of their profession?

1. Almost never
2. Not very often
3. Quite often
4. Usually
5. Almost always

12. To what extent do you think a medical doctor in a clinical team should consult with the team members, such as social worker, psychologist, etc., before making basic decisions in the management of the patient, such as discharge, referrals, or pronounced changes in therapy?

1. In none of his cases
2. In some of his cases
3. In about half of his cases
4. In most of his cases
5. In nearly all of his cases

13. How important do you think it is to have nonmedical specialists included on a treatment team in a medical setting?

1. Not important at all
2. Pretty unimportant
3. Not so important
4. Pretty important
5. Very important

14. The medical doctor in a clinical team consisting of psychologist, social worker, nurse, therapists, and technicians should take a decidedly directive rather than coordinating position if treatment is to be effective.

1. Strongly disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

15. How important do you think it is for a physician to actively participate in organized state public health programs?

1. Not important at all
2. Pretty unimportant
3. Not so important
4. Pretty important
5. Very important

16. A medical doctor is free to decide whether or not he wants to accept the opinion of a consultant.

1. Almost never
2. Seldom
3. Undecided
4. Qnite often
5. Almost always

17. In general clinical practice a medical social worker is unnecessary provided an experienced nurse is available.

1. Disagree completely
2. Disagree
3. Undecided
4. Agree for the most part
5. Agree completely

18. A medical doctor should accept the opinion of a consultant without reservation.

1. Never
2. Seldom
3. Undecided
4. Most of the time
5. Always

19. After a physician has explained the medical diagnosis and prognosis of a patient to his relatives he refers the family to the social worker for further discussion of their reactions to the patient's diagnosis and illness. How good a practice do you think this is?

1. A very poor practice
2. A somewhat poor practice
3. Undecided
4. A fairly good practice
5. A very good practice

20. A patient's ability to pay for medical services should not influence treatment given by the doctor.

1. Strongly agree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

21. Health supervision as compared with curative medicine is uninteresting and unprofitable to the physician.

1. Definitely not
2. No
3. Undecided
4. Yes
5. Definitely yes

22. Hygiene, often defined as the science of health, is as much a science as internal medicine and pediatrics.

1. Disagree completely
2. Disagree
3. Undecided
4. Agree
5. Agree completely

23. Specific knowledge necessary for prevention of disease is so limited at this state of development that the time of a practicing physician is much better spent in curative medicine.

1. Completely disagree
2. Disagree
3. Undecided
4. Agree for the most part
5. Completely agree

24. For a well-rounded medical education, work in pediatrics and surgery is decidedly more important than work in preventive medicine.

1. Strongly disagree
2. Disagree
3. Undecided
4. Agree
5. Strongly agree

25. Preventive medicine necessitates a degree of understanding of patient's attitude toward health and disease that is unusual in the current practice of medicine.

1. Completely disagree
2. Disagree
3. Undecided
4. Agree for the most part
5. Completely agree

26. In present day practice the demand for treatment of disease is so great that hardly any time can be spared to concern oneself with prevention of illness.

1. Completely disagree
2. Disagree
3. Undecided
4. Agree for the most part
5. Completely agree

27. How important do you think it is for a physician to participate in programs of accident prevention?

1. Not important at all
2. Pretty unimportant
3. Undecided
4. Pretty important
5. Very important

28. Since prevention of disease is directly related to the properties of disease itself, there is no special reason to teach the preventive aspects in separate courses.

1. Disagree completely
2. Disagree
3. Undecided
4. Agree
5. Agree completely

29. There is little value in stressing principles of disease prevention as personal habits of most adult patients are so firmly established that the possibility of effecting more lasting change is rather unlikely.

1. Disagree completely
2. Disagree
3. Undecided
4. Agree
5. Agree completely

30. Prevention of disease as a medical activity is primarily the responsibility of health departments rather than the responsibility of bedside physicians.

1. Disagree completely
2. Disagree
3. Undecided
4. Agree
5. Agree completely

PART III: THE R-O SCALE

Instructions: The following are questions concerning what students think and feel about a number of important social and personal questions. The best answer to each statement below is your personal opinion. We have tried to cover many different and opposing points of view; you may find yourself agreeing strongly with some of the statements, disagreeing just as strongly with others, and perhaps uncertain about others; whether you agree or disagree with any statement, you can be sure that many people feel the the same as you do.

Mark each statement in the left margin according to how much you agree or disagree with it. Please mark every one. Write +1, +2, +3, —1, —2, —3 depending on how you feel in each case.

+1: I agree a little
+2: I agree on the whole
+3: I agree very much
−1: I disagree a little
−2: I disagree on the whole
−3: I disagree very much

+3 +2 +1 —1 —2 —3 (1) It's all too true that the rich are getting richer and the poor are getting poorer.
+3 +2 +1 —1 —2 —3 (2) It is very foolish to advocate government support of religion.
+3 +2 +1 —1 —2 —3 (3) This much is certain: The only way to defeat tyranny in China is to support Chiang Kai-Shek.

+3 +2 +1 —1 —2 —3 (4) It's perfectly clear that the decision to execute the Rosenberg's has done us more harm than good.

+3 +2 +1 —1 —2 —3 (5) A person must be pretty short-sighted if he believes that college professors should be forced to take special loyalty oaths.

+3 +2 +1 —1 —2 —3 (6) It's mainly those who believe the propaganda put out by the real estate interests who are against a federal slum clearance program.

+3 +2 +1 —1 —2 —3 (7) Anyone who's old enough to remember the Hoover days will tell you that it's lucky thing Hoover was never reelected.

+3 +2 +1 —1 —2 —3 (8) The American rearmament program is clear and positive proof that we are willing to sacrifice to preserve our freedom.

+3 +2 +1 —1 —2 —3 (9) It's mostly the noisy liberals who try to tell us that we will be better off under socialism.

+3 +2 +1 —1 —2 —3 (10) It's usually the troublemakers who talk about government ownership of public utilities.

+3 +2 +1 —1 —2 —3 (11) History clearly shows that it is the private enterprise system which is at the root of depressions and wars.

+3 +2 +1 —1 —2 —3 (12) It's perfectly clear to all thinking persons that the way to solve our financial problem is by soak-the-rich tax program.

+3 +2 +1 —1 —2 —3 (13) It's already crystal clear that the United Nations is a failure.

+3 +2 +1 —1 —2 —3 (14) Anyone who is really for democracy knows very well that the only way for America to head off revolution and civil war in backward countries is to send military aid.

+3 +2 +1 —1 —2 —3 (15) There are two kinds of people who fought Truman's fair Deal program: the selfish and the stupid.

+3 +2 +1 —1 —2 —3 (16) It's the radicals and the labor racketeers who yell the loudest about labor's right to strike.

+3 +2 +1 —1 —2 —3 (17) A person must be pretty gullible if he really believes that the Communists have actually infiltrated into government and education.

+3 +2 +1 —1 —2 —3 (18) Only a misguided idealist would believe that the United States is an imperialist warmonger.

+3 +2 +1 —1 —2 —3 (19) Plain common sense tells you that prejudice can be removed by education, not legislation.

+3 +2 +1 —1 —2 —3 (20) It's the fellow travellers or reds who keep yelling all the time about Civil Rights.

+3 +2 +1 —1 —2 —3 (21) A person must be pretty stupid if he still believes in differences between the races.

+3 +2 +1 —1 —2 —3 (22) A person must be very ignorant if he things that Rockefeller is going to let the "big boys" run this country.

+3 +2 +1 —1 —2 —3 (23) Anyone who knows what is going on will tell you that Alger Hiss was a traitor who betrayed his country.

+3 +2 +1 —1 —2 —3 (24) Any person with even a brain in his head knows that it would be dangerous to let our country be run by men like General MacArthur.

+3 +2 +1 —1 —2 —3 (25) Thoughtful persons know that the American Legion is not really interested in democracy.

+3 +2 +1 —1 —2 —3 (26) Only a simple-minded fool would think that Senator Joseph McCarthy is a defender of American democracy.

+3 +2 +1 —1 —2 —3 (27) You can't help but feel sorry for those who believe that the world couldn't exist without the Creator.

+3 +2 +1 —1 —2 —3 (28) Any intelligent person can plainly see that the real reason America is rearming is to stop aggression.

+3 +2 +1 —1 —2 —3 (29) The truth of the matter is this: it is big business that wants to continue the cold war.

+3 +2 +1—1—2—3 (30) History will clearly show that Churchill's victory over the Labour Party in 1951 was a step forward for the British people.

+3 +2 +1—1—2—3 (31) Even a person of average intelligence knows that to defend ourselves against aggression we should welcome help—including Franco Spain.

+3 +2 +1—1—2—3 (32) It's the agitators and left-wingers who are trying to get Red China into the United Nations.

+3 +2 +1—1—2—3 (33) It's simply incredible that anyone should believe that socialized medicine will actually help solve our health problems.

+3 +2 +1—1—2—3 (34) It's the people who believe everything they read in the papers who are convinced that Russia is pursuing a ruthless policy of aggression.

+3 +2 +1—1—2—3 (35) It's mostly those who are itching for a fight who want a universal military training law.

+3 +2 +1—1—2—3 (36) It's perfectly clear to all decent Americans that congressional committees which investigate communism do more good than harm.

+3 +2 +1—1—2—3 (37) It's just plain stupid to say that it was Franklin Roosevelt who got us in the war.

+3 +2 +1—1—2—3 (38) A study of American history clearly shows that it is the American businessman who has contributed most to our society.

+3 +2 +1—1—2—3 (39) It is foolish to think that the Democratic Party is really the party of the common man.

+3 +2 +1—1—2—3 (40) Make no mistake about it! The best way to achieve security is for the government to guarantee jobs for all.

PART IV: THE PSHO-OAP SCALE

Instructions: In the following series of questions we are interested in your opinion about poor people in general. We are interested in your own personal opinion therefore there are no "right" or "wrong" answers. Please indicate how you feel about each statement by deciding if you agree or disagree, and the strength of your opinion. Then circle the appropriate number in front of the statement in the following fashion:

+3: Strongly agree
+2: Moderately agree
+1: Slightly agree
0: Uncertain
—1: Slightly disagree
—2: Moderately disagree
—3: Strongly disagree

Many of the statements may seem absurd and impossible to answer by simply noting how strongly you agree or disagree. Nevertheless, answer every item even if you must guess at some. Keep in mind that the questions concern the *URBAN POOR* in general and not any specific minority group.

+3+2+1 0 —1—2—3 (1) Most poor people are poor because they are lazy.

+3+2+1 0 —1—2—3 (2) There is little antagonism or conflict between poor parents and their children.

+3+2+1 0 —1—2—3 (3) The poor are greatly concerned with gaining social status and prestige.

+3+2+1 0 —1—2—3 (4) Children in poor families are expected to obey parental authority immediately.

+3+2+1 0 —1—2—3 (5) Wives of the poor frequently face the threat of desertion.

+3+2+1 0 —1—2—3 (6) The poor generally resist innovation in preference for traditional ways of doing things.

+3+2+1 0 —1—2—3 (7) The poor would rather learn things from books than from other people.

+3+2+1 0 —1—2—3 (8) While desiring a good standard of living, the poor are not attracted to a middle class style of life.

+3+2+1 0 —1—2—3 (9) Most poor families are dominantly concerned with "getting by" rather than "getting ahead."

+3+2+1 0 —1—2—3 (10) The poor are compensated for their poverty by enjoying a more sensual life.

+3+2+1 0 —1—2—3 (11) The poor usually find it difficult to have informal, comfortable relationships with other persons.

+3+2+1 0 —1—2—3 (12) The poor are not readily open to reason.

+3+2+1 0 —1—2—3 (13) The poor are not class conscious, although aware of class differences.

+3+2+1 0 —1—2—3 (14) The poor usually read very little and ineffectively.

+3+2+1 0 —1—2—3 (15) In poor families there is a great deal of family discord and interpersonal conflict.

+3+2+1 0 —1—2—3 (16) The poor generally think of intellectuals as "egg-heads."

+3+2+1 0 —1—2—3 (17) Generally the poor have a considerable interest in encouraging a college education for their children.

+3+2+1 0 —1—2—3 (18) The poor prefer passive entertainment such as movies to active entertainment such as parties and dances.

+3+2+1 0 —1—2—3 (19) The poor are able to build abstractions, but it is done in a slow, physical fashion.

+3+2+1 0 —1—2—3 (20) The poor are usually not interested in planning for long-term goals, but rather prefer immediate gratification of needs.

+3+2+1 0 —1—2—3 (21) One of the major problems of the poor is unemployment and the threat of layoff.

+3+2+1 0 —1—2—3 (22) The poor generally judge a political candidate on the basis of personality rather than on qualifications or platform.

+3+2+1 0 —1—2—3 (23) The poor family is frequently "child-centered."

+3+2+1 0 —1—2—3 (24) The poor are largely uninterested in politics.

+3+2+1 0 —1—2—3 (25) The poor prefer abstract planning to direct, concrete action in attaining goals.

+3+2+1 0 —1—2—3 (26) The grandparents, uncles, aunts and cousins of the poor usually maintain close family ties.

+3+2+1 0 —1—2—3 (27) The poor view most political leaders as corrupt "bigshots."

+3+2+1 0 —1—2—3 (28) The poor prefer voluntary associations to be loosely organized to those with more structure.

+3+2+1 0 —1—2—3 (29) In poor families the husband is generally not the dominant authority figure.

+3+2+1 0 —1—2—3 (30) The poor are quite well informed about most social and political issues.

+3+2+1 0 —1—2—3 (31) The poor prefer strong, directive leadership to that of nondirective leadership.

+3+2+1 0 —1—2—3 (32) The poor generally have sufficient contact with most social institutions such as the school.

+3+2+1 0 —1—2—3 (33) Humor among the poor often takes the form of physical acts such as "horseplay."

+3+2+1 0 —1—2—3 (34) The duties of husbands and wives are not sharply differentiated in poor families.

+3+2+1 0 —1—2—3 (35) Usually the poor will accept jobs that provide moderate economic security as opposed to those involving risk but the possibility of high monetary return.

+3+2+1 0 —1—2—3 (36) Most poor people believe that the "insanity plea" is not a legitimate defense in a criminal trial.

+3+2+1 0 —1—2—3 (37) The poor usually hold flexible opinions.

+3+2+1 0 —1—2—3 (38) The outstanding weakness of the poor is a lack of education.

+3+2+1 0 —1—2—3 (39) The poor rarely have firm convictions about such issues as religion, morality and custom.

+3+2+1 0 —1—2—3 (40) Physical punishment is the basic disciplinary technique for the children of the poor.

+3+2+1 0 —1—2—3 (41) Most poor people are not willing to work even if given the opportunity.

+3+2+1 0 —1—2—3 (42) The poor are an outgoing, friendly and amiable people.

+3+2+1 0 —1—2—3 (43) The poor rarely rely on such facilities as banks, hospitals and department stores.

+3+2+1 0 —1—2—3 (44) There is a considerable amount of preoccupation with sex among the poor.

+3+2+1 0 —1—2—3 (45) The wives of the poor generally accept a tradtionally submissive role in relation to their husband.

+3+2+1 0 —1—2—3 (46) Mothers in poor families tend to deprive their children of matternal affection.

+3+2+1 0 —1—2—3 (47) Even the poor who show initiative and industry are prevented from improving their lot by overwhelming circumstances.

+3+2+1 0 —1—2—3 (48) Most poor people are concerned with the future rather than the present "here and now."

+3+2+1 0 —1—2—3 (49) There is a high incidence of common-law marriages among the poor.

+3+2+1 0 —1—2—3 (50) The poor tend to be narrow-minded and self centered.

+3+2+1 0 —1—2—3 (51) The poor are generally isolated and withdrawn from their own community.

+3+2+1 0 —1—2—3 (52) The poor have a low level of literacy.

+3+2+1 0 —1—2—3 (53) Children of the poor generally do not have long protected childhoods.

+3+2+1 0 —1—2—3 (54) In most poor areas there is an absence of local community spirit.

+3+2+1 0 —1—2—3 (55) There is a good deal of metaphor and analogy used in the language of the poor.

+3+2+1 0 —1—2—3 (56) The poor are not easily capable of kindness, generosity and compassion.

+3+2+1 0 —1—2—3 (57) The poor are tough people who cope with problems that would overwhelm many middle class individuals.

+3+2+1 0 —1—2—3 (58) The poor tend to be provincial and ethnocentric.

+3+2+1 0 —1—2—3 (59) Children of the poor are initiated into sex late in life.

+3+2+1 0 —1—2—3 (60) The poor are members of few social organizations beyond that of the family.

+3+2+1 0 —1—2—3 (61) The poor live in areas in which there are numerous murderers, drug addicts, thieves and prostitues.

+3+2+1 0 —1—2—3 (62) The poor are quite impulsive in their behavior.

+3+2+1 0 —1—2—3 (63) The poor usually belong to numerous voluntary associations.

+3+2+1 0 —1—2—3 (64) Most poor persons consider poverty to be their fate.

(65) Most poor persons have a feeling of helplessness, dependency and
+3+2+1 0 —1—2—3 inferiority.

+3+2+1 0 —1—2—3 (66) The poor have a basic distrust of the police.

+3+2+1 0 —1—2—3 (67) The language used by the poor is simple, direct and earthy.

+3+2+1 0 —1—2—3 (68) The poor are aware of middle class values and try to live by them.
+3+2+1 0 —1—2—3 (69) There is a high incidence of illegitimate children among the poor.
+3+2+1 0 —1—2—3 (70) The poor show a need for excitement, new experience and adventure.

PART V: THE SMA SCALE

Instructions: This is a study of what medical students and people in general think about a number of social and medical questions. The best answer to each statement below is your personal opinion.

Please indicate your response to the following statements using these alternatives:

+2: Strongly agree
+1: Agree
0: Undecided
—1: Disagree
—2: Strongly disagree

+2+1 0 —1—2 (1) The quality of medical care under the system of private practice is superior to that under a system of socialized medicine.
+2+1 0 —1—2 (2) Socialized medicine will produce a healthier and more productive population.
+2+1 0 —1—2 (3) Under the socialized medicine there would be less incentive for young men to become doctors.
+2+1 0 —1—2 (4) Socialized medicine is necessary because it brings the greatest good to the greatest number of people.
+2+1 0 —1—2 (5) Treatment under socialized medicine would be mechanical and superficial.
+2+1 0 —1—2 (6) Socialized medicine would be realization of one of the true aims of a democracy.
+2+1 0 —1—2 (7) Socialized medicine would upset the traditional relationship between the family doctor and the patient.
+2+1 0 —1—2 (8) I feel that I would get better care from a doctor whom I am paying than from a doctor who is being paid by the government.
+2+1 0 —1—2 (9) Despite many practical objections, I feel that socialized medicine is a real need of the American people.
+2+1 0 —1—2 (10) Socialized medicine could be administered quite efficiently if the doctors would cooperate.
+2+1 0 —1—2 (11) There is no reason why the traditional relationship between doctors and patient cannot be continued under socialized medicine.
+2+1 0 —1—2 (12) If socialized medicine were enacted, politicians would have control over doctors.
+2+1 0 —1—2 (13) The present system of private medical practice is the one best adapted to the liberal philosophy of democracy.
+2+1 0 —1—2 (14) There is no reason why doctors should not be able to work just as well under socialized medicine as they do now.
+2+1 0 —1—2 (15) More and better care will be obtained under socialized medicine.
+2+1 0 —1—2 (16) The atmosphere of socialized medicine would destroy the initiative and the ambition of young doctors.
+2+1 0 —1—2 (17) Politicians are trying to force socialized medicine upon the people without giving them the true facts.
+2+1 0 —1—2 (18) Administrative costs under socialized medicine would be exorbitant.
+2+1 0 —1—2 (19) Red tape and bureaucratic problems would make socialized medicine grossly inefficient.
+2+1 0 —1—2 (20) Any system of socialized medicine would invade the privacy of the individual.

PART VI: THE ATS SCALE

Instructions: This last series of questions survey students opinion on the issue of segregation. Please indicate your response to the statements using these alternatives:

+3: Strongly agree
+2: Moderately agree
+1: Slightly agree
—1: Slightly disagree
—2: Moderately disagree
—3: Strongly disagree

+3+2+1—1—2—3 (1) Racial segregation is an effective and practical social arrangement which has no serious effect on the vitality of democratic ideals.

+3+2+1—1—2—3 (2) The Negroes' main concern is with equal educational opportunities. They have no intention of interferring with the social patterns of the white community.

+3+2+1—1—2—3 (3) The best safeguard of a democracy is the solid stability of social tradition such as is involved in the maintenance of segregation.

+3+2+1—1—2—3 (4) Integration threatens one of the principles of democracy, the right of each citizen to choose his own associates.

+3+2+1—1—2—3 (5) The end of segregation would bring a continuing increase in social conflict and violence.

+3+2+1—1—2—3 (6) Although the IQ of Negroes in the South is on the whole lower than the IQ of whites, this difference in intelligence is mainly due to lack of opportunity for the Negro and will eventually disappear under an integrated school system.

+3+2+1—1—2—3 (7) Since integration will require some painful adjustments to be made in changing from segregated schools, the best solution will be to leave the races segregated.

+3+2+1—1—2—3 (8) Equal educational exposures in integrated schools will help both the Negro and white students to profit from the best of two cultures.

+3+2+1—1—2—3 (9) Desegregation can in most cases be accomplished without being followed by social conflict and violence.

+3+2+1—1—2—3 (10) Improving Negro education via integregation will lead to a higher standard of living in the South accompanied by more and better jobs for everybody.

+3+2+1—1—2—3 (11) The Supreme Court's decision on segregation was a politically inspired invasion of states' rights and represents a miscarriage of justice.

+3+2+1—1—2—3 (12) The Negro race is physically and mentally inferior to the white race and integregation would not help to erase the innate differences between the two races.

+3+2+1—1—2—3 (13) Integregated and therefore better education for the Negro via integration is certain to result in increased feelings of responsibility and cooperation in his part.

+3+2+1—1—2—3 (14) The successes of already completed integration attempts are clear evidence that the fears of extreme pro-segregationists are unfounded.

+3+2+1—1—2—3 (15) Negroes who are given the opportunity to go to integrated schools are apt to become demanding, officious and overbearing.

+3+2+1—1—2—3 (16) Although certain radical Negro leaders try to make people think otherwise, the majority of Negroes do not want integration and would be satisfied with "equal but separate" school facilities.

+3+2+1—1—2—3 (17) Desegration will develop a false sense of power among Negroes and will move us closer to having a "Negro party" in America.

+3+2+1—1—2—3 (18) The South has failed to adequately draw upon the resources of the Negro race and integrated schools will enable the Negro to make a greater contribution to the South economically and socially than they have been able to make with segregated schools.

+3+2+1—1—2—3 (19) Once you start letting Negroes attend the schools of whites they will demand complete social equality in all respects including dating and club privileges.

+3+2+1—1—2—3 (20) The desegregation law is basically unfair to the Negroes who will now have to compete on equal terms with the whites.

+3+2+1—1—2—3 (21) Negroes and whites will find it easier to get along together in the same school than most people think.

+3+2+1—1—2—3 (22) In dealing with the problems of desegregation we should always act in terms of the Christian rule of brotherhood and justice for all and not in terms of social attitudes based on tradition.

+3+2+1—1—2—3 (23) The practice of segregation cannot help but reduce our political influence in international affairs.

+3+2+1—1—2—3 (24) Desegregation will lead to a permanent lowering of standards in the public schools.

+3+2+1—1—2—3 (25) Desegregation is economically wise since the South's poor economic state may in part be due to the double expense of segregation.

APPENDIX 4

Guidelines for Problem and Community Papers

MEMO TO: PRECEPTORS AND PROJECT WORKERS INVOLVED IN GROUP WORK, TEACHING CLASSES, LEADING RECREATION, AND OTHER KINDS OF ACTIVITIES WITH COMMUNITIES AND ORGANIZATIONS.

FROM: KAREN LYNCH

SUBJECT: PROBLEM PAPERS (YELLOW GUIDELINES 1)

You should present your activities of the summer from several points of view. I would like you to *focus on the problems and conflicts you have encountered* in working with your group or community.

You'll probably make the greatest impact by describing specific problems and specific examples of the things which have happened this summer. Focusing on problems and conflicts will highlight the critical issues you've encountered. These may appear to be "personality problems," or misunderstandings between you and community people or you and health producers. Examine these problems from the *point of view of the process of getting services to people.*

These guidelines may help in thinking about your activities:

1. Groups. If you've been in contact with groups of people—through recreation programs, sex education classes, group therapy, day camp, psychiatric followup, or other similar activity—describe your activities with these groups, your intentions or plans for the groups and the development of these activities. Speak in examples including time, names, and identifying information.
2. Health problems. If you have come across health problems, become involved with attempts to meet health needs, discovered gaps in information about health services, or misinformed attitudes, describe these problems in detail and your attempts to deal with them.
3. Resources. If you have become aware of resources at your site—people, experience, organizations, places—which can be effectively utilized in the delivery of health services, describe these, how you found them, and what potential they offer.

The most vivid and striking approach to this is by presenting one incident or project activity. This incident should point out a problem in the health care system or in community's response to health issues. It should show how you decided to deal with it, what help, difficulty, or indifference you received from the medical "establishment," and what help, difficulty, or indifference you encountered from communities. Be as specific as possible in your descriptions and analysis.

RETURN THE PROBLEM PAPER TO KAREN LYNCH. SHO OFFICE, *BY AUGUST 14, 1968*

MEMO TO: PRECEPTORS AND PROJECT WORKERS INVOLVED IN THE DEVELOPMENT OF SERVICES, COMMUNITY ORGANIZING, PLANNING WITH COMMUNITIES, ACTING ON SURVEY FINDINGS.

FROM: KAREN LYNCH

SUBJECT: PROBLEM PAPERS (YELLOW GUIDELINE 2)

1. What is the central issue you've worked on this summer?
2. Why is this an issue, who identified it, and who wanted action on it?
3. Describe what you've been doing this summer, *focusing on the problems and conflicts you have encountered*. You may want to include a chronology of activities, including names, titles, and ways of contacting people of the community and of the "establishment."

   Include a description of how the medical establishment (or nonhealth establishment) related to your summer's activities—the cooperation, conflicts, and problems you encountered with them and how you dealt with them. Describe specific incidents.

   Include a description of the way health consumers, community, patients, clients related to your activities. Were they resposive, hostile, cooperative? How did you deal with their reactions. Describe specific incidents.

RETURN THE PROBLEM PAPER TO KAREN LYNCH, SHO OFFICE, *BY AUGUST 14, 1968*

MEMO TO: PROJECT WORKERS INVOLVED IN SURVEY WORK AND STUDIES PRECEPTORS.

FROM: KAREN LYNCH

SUBJECT: PROBLEM PAPERS (YELLOW GUIDELINE 3)

1. Why did you undertake the survey or study? What, in other words, is the rationale, justification, or purpose of the survey or study?
2. What is the intended use of your survey or study? Who, what group, is involved?
3. Who asked that it be done? Who supervises or has overall responsibility for it?
4. How did you go about setting up your survey or study? Describe the planning and who was involved, the design of the study, sampling procedures, development of survey, and so on. Tell as much as you can about the problems of developing the study and working up the findings.
5. Did you follow through and use the instrument—survey? Did you present (or are you presenting) a report? To whom?
6. Did you encounter hostile or cooperative responses by those interviewed or studied? Does this tell you anything about the attitudes of your population?
7. What are the *descriptive findings* of the survey or study?
8. What were your *results* in terms of problems to deal with and action on findings?

If you have presented a report to your site or anyone else, please enclose a copy of that with your problem paper.

If you acted on survey findings or undertook the development of services, use one of the yellow guidelines for presenting those activities. If those guidelines are inappropriate, go ahead and explain in your own terms what happened after the survey or study was completed.

RETURN THE PROBLEM PAPER TO KAREN LYNCH, SHO OFFICE, *BY AUGUST 14, 1968*

MEMO TO: PROJECT WORKERS IN COMMUNITIES

FROM: KAREN LYNCH

COMMUNITY PAPERS (GREEN GUIDELINE)

You know the local community where you are working this summer. Others concerned with the delivery of health services don't know your community. I would like you to use the questions on this green page as a guideline for writing a description of the local community you are working in.

This description of the local community should be written with the cooperation and approval of your preceptor and organization. Nothing should be included which you or your community would find objectionable. The purpose of these questions is *to provide Philadelphia SHO and others interested in getting health care to local communities with information about your community so that they will be a better informed position in planning their programs with local communities.*

1. How is your community defined? Indicate geographical boundaries and characteristics of the people and the area which are important. (Keep this description relevant, but brief.)
2. What services are provided your community and how adequate are these services? Some of the services you may wish to comment on are transportation system, shopping, schools, rubbish and trash collection, police protection, and recreation.
3. More specifically, what is the condition of the health care system in your community? What services are known and not known? What is the response of the community to present services.
4. What major community health problems have you encountered this summer?
5. Has the community been involved with health planning? Describe experiences you have been involved with and experiences you have heard about.
6. From your experience in the community, if you want to get things done, how do you go about it? If you have a plan or a grievance, for example, how do you go about acting on it in your community?

As I mentioned above, these are *only guidelines* for presenting your community in such a way that those who haven't had the experience of working with it will have some idea of your community and health services. I suggest that you keep the paper brief but accurate.

RETURN THE PROBLEM PAPER TO KAREN LYNCH, SHO OFFICE, *BY AUGUST 14, 1968*

APPENDIX 5

Personal Contacts

PHILADELPHIA STUDENT HEALTH ORGANIZATION
PERSONAL CONTACTS SHEET

Contactor ________ CW___ HHS___ YI___
State ________ Date ________
Time: Begin ________ End ________

1. NAME OF CONTACT ________
   - ☐ Male
   - ☐ Female
   - ☐ Puerto Rican
   - ☐ Negro
   - ☐ White
   - ☐ Age ________
   - ☐ Last year of school completed ________

2. STATUS OF PERSON CONTACTED
   - ☐ Community worker ________
   - ☐ Community leader ________
   - ☐ Health professional ________
   - ☐ Nonhealth professional ________
   - ☐ Medical technician ________
   - ☐ City government official ________
   - ☐ Other SHO worker ________
   - ☐ Other ________

3. CONTACT SITUATION
   - ☐ Person contacted by phone
   - ☐ Person contacted in person
   - ☐ Person contacted individually
   - ☐ Size of group ________
   - Names of others contacted in group ________

   ____

   ____

   - ☐ First contact with person
   - ☐ Contactor initiated meeting
   - ☐ Contact initiated meeting
   - ☐ Other initiated meeting

4. CIRCUMSTANCES OF CONTACT

   Place of Contact
   - ☐ Home of contact ________
   - ☐ Community health center ________
   - ☐ Welfare Agency ________
   - ☐ On the street ________
   - ☐ Hospital ________
   - ☐ Other ________

   ____

   - ☐ Contact was intentionally planned
   - ☐ Contact was part of some other activity
   - ☐ There will be follow-up contact with this person
   - ☐ There will not be follow-up contact with this person

5. PURPOSE OF CONTACT
   - ☐ Investigate housing conditions
   - ☐ Self education
   - ☐ Self education
   - ☐ Resource for further work
   - ☐ Patient advocacy
   - ☐ Referrals
   - ☐ Providing medical services
   - ☐ Other ________

   ____

6. DESCRIBE BRIEFLY WHAT ACTION WAS TAKEN

   ____

   ____

7. EVALUATION OF CONTACT

   The person contacted seemed to be satisfied 5 4 3 2 1 unsatisfied with the contact.
   The person contacted seemed to be interested 5 4 3 2 1 disinterested in the contact.
   The person contacted seemed to be cooperative 5 4 3 2 1 uncooperative in the contact.
   The person contacted seemed to feel that the contact was a success 5 4 3 2 1 a failure.
   I think that the contact was a success 5 4 3 2 1 a failure.

8. If possible, please state the results of the contact in terms of special accomplishments. ________

   ____

   ____

   ____

9. Additional comments:

Contact Sheets as a Research Technique

The purpose of asking project workers at Spring Garden Community center and St. Christopher's Child and Comprehensive Care Center to report on their personal contacts was to experiment with a reporting method which might provide unique and previously untapped data regarding the deficiencies of the health care system and to help develop an evaluational technique for future SHO research projects. The "personal contact sheet" has various merits and demerits in this regard.

Probably the most suitable usage of the checklist would be for students to complete it on an individual basis, over the course of the summer, and use it as a reference to write an end-of-summer report. In this sense the contact report sheets are an adequate, quickly completed format by which students can make daily logs of their activities and use them as a personal record for a final report. The contact sheets do not seem suitable for the method used in this research—that is, as a report to a central research unit. The central unit is too distant from the daily activities to make a valuable report on health system deficiencies. If in the case of the present research, each project worker had utilized his own contact sheets as a reference to write a report on the health system, it would have been for more factual, informative, specific, detailed and readable than the attempt by a removed person to integrate and summarize a second party's summer work activities. For example, had the health science student at St. Christopher's used his own contact sheets in regard to attracting teenage gangs to sex education classes, he would be able to present a more expressive and sensitive account than can a researcher who is uninvolved with the activity first hand.

The "contact report sheet" then seems to be most applicable as a personal accounting form for use by the individual project workers. Should this form be used in future research, it should be modified to a certain extent and students should be thoroughly briefed on its purpose. The modifications should expand the sections on purpose of contact, action taken and accomplishments of contact. An effort should be made to encourage a more elaborate reporting on these items; otherwise, the remaining data have no relevance. This might be accomplished by encouraging students to make more detailed notes rather than attempting to develop additional questions.

Also, any future use of this form should ask for the occupation of the person contacted and his title, and the specific name of the agency or organization for which the person contacted works. As a reporting technique to a central researcher, however, its usage is not recommended.

APPENDIX 6

Project List: Project Sites and Participants

Black Summer

Preceptor: Lee Montgomery, Office of Urban Affairs, Temple University.

Project workers: Mike Roth (HSS), Bob Sussman (HSS).

Area coordinator: Paul Fernhoff.

CEPA—Consumer's Education and Protective Association

Preceptor: Max Weiner, 6048 Ogontz Avenue.

Project workers: Clarissa Cain (CW), Garland Dempsey (CW), Jane Friedman (HSS), Steve Marder (HSS).

Area coordinator: Paul Fernhoff.

Citizen Concerned for Welfare Rights

Preceptor: Leona Thomas, 741 North Preston Street.

Project workers: Kathryne Dunbar (CW), Dorothy Federman (HSS), Ida Floyd (CW).

Area coordinator: Jay Federman.

Delaware County Health and Welfare (Citizens for Better Public Health)

Preceptor: Peter Brigham.

Project workers: Jan Baxt (HSS), Sheldon Halpern (HSS).

Area coordinator: Dick Devereux.

Eagleville Hospital

Preceptor: Donald Ottenberg, M.D., Eagleville Hospital and Rehabilitation Center, Eagleville, Pa.

Project workers: Debbie Finkelstein (HSS), Darryl Robbins (HSS).

Area coordinator: Paul Fernhoff.

Eastwick Community Organization

Preceptors: Regina Eichinger, 8508 Harley Avenue; Joan Baker, 2816 South 81st Street.

Project workers: Andrea Benn (YI), Clark Bird (YI), Renee Edwards (YI), Eileen Fair (HSS), Paul Frame (HSS), Bill Woods (HSS).

Area coordinator: Dick Devereux.

Experiment in Community Action

Project worker: Lucia Siegel (HSS).

Fairmont Community Council

Preceptor: Marion Hilliard, 3956 Pennsgrove Street.

Project workers: Frank Ferri (HSS), Steve Fox (HSS), Nathan Smith (YI).

Area coordinator: Jay Federman.

Fishtown Civic Association

Project worker: Bill Halperin (HSS).

Area coordinator: Cleve Dawson.

Gray's Ferry

Preceptor: Velva Taylor, 1337 South 28th Street.

Project workers: Rich Bonanno (HSS), Rhoda Halperin (HSS), Francine Lewis (CW).

Area coordinator: Paul Fernhoff.

Haddington Homes

Preceptor: Mary Voughn, 5448 Aspen Place.

Project workers: Keith Hansen (HSS), Mary Rich (CW).

Area coordinator: Jay Federman.

Hartranft Community Corporation

Preceptor: Hector Rodriques, 3257 Germantown Avenue.

Project workers: Yvonne Butterfield (HSS), Charles Cook (YI), David Eisenberg (HSS), Natlire Thornton (CW), Van Williams (CW), Heidi Wolf (HSS).

Area coordinator: Cleve Dawson.

Hawthorne Community Center

Preceptors: Charles Floyd, 5215 Spruce Street; Caryl Heimer, M.D., 235 South Third Street; Jefferson C & Y, 1332 Fitzwater Street; Hawthorne Community Center.

Project workers: Susan Oster (HSS), Don Sesso (HSS), Nate Williams (CW).

Area coordinator: Mary Lou Evitts.

Holmesburg Prison

Preceptor: Norman Jablon, M.D., Holmesburg Prison, Torresdale Avenue.

Project workers: Alan Cohler (HSS), Lawrence Kron (HSS).

Area coordinator: Paul Fernhoff.

Horizon House

Preceptors: Armin Loeb, M.D., Research Director, 1825 Pine Street; Audrie Russell, Director of Case Workers, 1823 Pine Street; Lee Booth, Director of Residence, 504-6 South 42d Street.

Project workers: Steve Ager (HSS), Jim Padget (HSS).

Area coordinator: Mary Lou Evitts.

Jefferson Community Mental Health

Preceptor: Jerry Jacobs, Junto Building, 12th and Walnut Street; John Mock, M.D., Philadelphia General Hospital.

Project workers: Mike Geha (HSS), Payle Jones (HSS).

Area coordinator: Mary Lou Evitts.

Ludlow Community Association

Preceptor: Marvin Lewis, 1233 North Franklin Street.

Project workers: Darlene Bredell (YI), Gustine Bredell (CW), Jerry Braverman (HSS), Carol Dinkerlacker (HSS), Peter Eisenberg (HSS), Richard Lockett (HSS), Denise Smith (YI), Brenda Williams (CW).

Area coordinator: Cleve Dawson.

Mantua Community Planners

Preceptors: Forrest Adams; John Ciccone; MCP Workshop, 3625 Wallace Street.

Project workers: Phil Graitcer (HSS), Frank Hart (YI), Ken Logan (HSS), William Roundtree (CW).

Areea coordinator: Jay Federman.

Mill Creek

Preceptor: Onna Parker, 709 June Court.

Project Worker: Claudia Mills (YI), David Stewart (HSS).

Area coordinator: Jay Federman.

Misericordia Hospital

Preceptors: Henry Hunter, Department of Public Relations, 54th and Cedar Avenue; Dr. Lynch, Department of OB GYN, 54th & Cedar Avenue; Dr. Hesch, Outpatient Department, 54th & Cedar Avenue.

Project workers: Gwendolyn Anthony (CW), Richard Bremer (HSS), Dan Brzusek (Hss), Willie Mae Harris (CW), Leonore Lee (CW), Susan Skulnick (HSS), Bettina Stronach (HSS).

Area coordinator: Dick Devereux.

North City Congress

Preceptors: Alvin E. Nichols, Director; Steve Turner, Mr. Cameron, Tony Lewis, 1428 North Broad Street.

Project workers: Meredith Hand (HSS), Stanley Reynolds (HSS).

Area coordinator: Cleve Dawson.

Ogden Civic Association

Preceptor: Mamie Weaver, 4117 Ogden Street.

Project workers: Martha Arey (HSS), Alma McElroy (YI).

Area coordinator: Jay Federman.

Preceptors: Mike Simmons, 3702 Spring Garden Street; Lou Ellen Williams, 7235 Paschall Avenue; Rhoda Houston, 7225 Greenway Avenue.

Project workers: Lawrence Budner (HSS), Renel Burden (YI), Dudley Goetz (HSS), Chris White (YI).

Area coordinator: Dick Devereux.

Pernet Family Health Service (Little Sisters of the Assumption)

Preceptors: Sister Rita, Sister Marguerite, 1001 South 47th Street.

Project worker: Joan Gomes (HSS).
Area coordinator: Dick Devereux.

Presbyterian Hospital

Preceptor: Neville R. Vines, 51 North 39th Street.
Project workers: Frank Greer (HSS), Garnette Hicks (CW), Jerry Lozner (HSS), Wilhelmina Seamon (CW).
Area coordinator: Jay Federman.

Southwest Center City Community Council (SWCC)

Preceptor: Joseph Cooper, 1732 Catherine Street.
Project workers: Isma Jackson (CW), Carla Oswald (HSS), Ed Pisko (HSS).
Area coordinator: Mary Lou Evitts.

Spring Garden

Preceptor: Pat Story, M.D., 1812 Green Street.
Project workers: Anita Costa (HSS), Tom Fiss (HSS), Walley Pillich (YI), William Smith (YI).
Areea coordinator: Paul Fernhoff.

Spruce Hill Community Association

Preceptor: David E. Boyce, Department of City and Regional Planning, University of Pennsylvania, 4428 Pine Street.
Project workers: Stephen Terzian (HSS).
Area coordinator: Dick Devereux.

St. Christopher's Child and Youth Comprehensive Care Center

Preceptor: Evelyn B. Wilson, Director; Nina Perry, Mrs. Kennedy.
Project workers: Dick Bagge (HSS), Forrest Lange (HSS), Richard Morrison (YI), Hetherwich Ntaba (HSS).
Area coordinator: Cleve Dawson.

Temple Community Mental Health Center

Preceptors: Stanton B. Felzer, Ph.D., Assistant Director; Alvin Thomas, Director, Community Organization, 1531 West Tioga Street.
Project workers: Bess Aronian (HSS), Philip Harber (HSS), Anne Sheehan (HSS).
Area coordinator: Cleve Dawson.

University Settlements

Preceptors: Jerry Gardner, Mike Norris, 2601 Lombard Street.
Project workers: Art Pressman (HSS), Bill Robinson HSS).
Area coordinator: Mary Lou Evitts.

Welfare Rights Organization

Preceptor: Roxanne Jones, 1520 Green Street; 1021 South Fourth Street.
Project workers: Marpha Crafton (YI), Shirley Fischer (HSS), Gene Shatz (HSS), John Zonano (HSS), Jean Wilkerson (YI).
Area coordinator: Dick Devereux.

West Philadelphia Community Mental Health Consortium

1. *Trouble Clinic.*
Preceptors: Jacob Schuts, M.D.; Gordon Podensky, 5001 Woodland Avenue.
Project workers: Bart Butta (HSS), Robert Lewy (HSS)
Area coordinator: Dick Devereux.
11. *Recreation Project.*
Preceptor: Christine Westfall, PGH.
Project workers: Richard Bernstein (HSS), Harry Hirsh (HHS), Lucia Sosnowski (HSS).
Area coordinator: Dick Devereux.

Young Great Society

Preceptors: Lillian Johnson; William Spotwood, 603 North 33d Street.
Project workers: Ivan Cohen (HSS), Thomas Devlin (HSS), Freida Farlow (CW), Patricia Ford (YI).
Area coordinator: Jay Federman.

Project Staff

Director: Robert L. Leopold, M.D.
Student directors: Chip Smith, Ron Blum, Elaine Haagen.
Research directors: Karen Lynch, Jon Snodgrass.
Area coordinators: Cleve Dawson, Dick Devereux, Mary Lou Evitts, Jay Federman, Paul Fernhoff.
Secretaries: Carrolyn Morgan, Rita Boler, Edith Barnhill.
Advisory council: Walter J. Lear, M.D., Sue Leslie; Jim Shelton; William A. Steiger, M.D.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Philadelphia Student Health Project—Summer 1968

☆ U.S. GOVERNMENT PRINTING OFFICE: 1969 O—355-229